Public Trust Board

Lister Education Centre, Lister Hospital, Stevenage

06/09/2023 10:30 - 12:30

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For noting				

22. Date of Next Meeting

Wednesday 1 November 2023

East and North Hertfordshire NHS Trust

Agenda item: 4

EAST AND NORTH HERTFORDSHIRE NHS TRUST

Minutes of the Trust Board meeting held in public on Wednesday 5 July 2023 at 10.30am in the Lister Education Training Centre, Lister Hospital, Stevenage

Present:	Mrs Ellen Schroder	Trust Chair
	Mrs Karen McConnell	Deputy Trust Chair and Non-Executive Director
	Dr David Buckle	Non-Executive Director
	Dr Peter Carter	Non-Executive Director
	Ms Val Moore	Non-Executive Director
	Mr Jonathan Silver	Non-Executive Director
	Mr Adam Sewell-Jones	Chief Executive Officer
	Mr Martin Armstrong	Director of Finance & Deputy Chief Executive Officer
	Mr Justin Daniels	Medical Director
	Ms Lucy Davies	Chief Operating Officer
	Mr Kevin Howell	Director of Estates and Facilities
	Ms Theresa Murphy	Chief Nurse
	Mr Kevin O'Hart	Director of Improvement
	Mr Thomas Pounds	Chief People Officer
	Mr Mark Stanton	Chief Information Officer
From the Trust:	Mr Stuart Dalton	Head of Corporate Governance
	Ms Karla West	Assistant Trust Secretary (Minutes)

No	Item	Action
23/023	**CHAIR'S OPENING REMARKS** Mrs Ellen Schroder welcomed Ms Sarah Corrigan who would present the staff story. The Staff Awards also took place that evening.	
23/024	**APOLOGIES FOR ABSENCE** Apologies were received from: Ms Claudia Montgomery – Deputy Director of Estates and Facilities Ms Lorraine Williams – Deputy Director of Infection Prevention & Control and Lead Nurse	
23/025	**DECLARATIONS OF INTEREST** There were no new declarations of interest made. All Non-Executive Directors were encouraged to file their annual returns	

online.

23/026 MINUTES OF PREVIOUS MEETING

The minutes of the previous meeting held on 5 May 2023 were **APPROVED** as an accurate record of the meeting subject to minor changes by Mrs Schroder.

23/027 ACTION LOG

The Board **NOTED** the completed Action Log.

23/028 QUESTIONS FROM THE PUBLIC

There were no questions from the public.

23/029 STAFF STORY

Mr Pounds explained that the staff story was important as it followed up from the civility video previously seen by the Board.

Ms Corrigan provided the background story of a staff member who had experienced and survived domestic abuse.

Concerns had been expressed regarding staff experiencing domestic abuse and it was questioned what East and North Hertfordshire NHS Trust could do to support staff and ensure further awareness was raised on this issue. Stalls had been organised both at the new Queen Elizabeth II Hospital and at Hertford Hospital where 16 days of raising awareness had occurred. This had been organised through the safeguarding committee, but we need to maintain awareness raising. Work had been a safe space for the member of staff who had survived the domestic abuse. Both her manager and matron had listened to the individual and their compassionate interaction was fundamental to helping her.

It was suggested that nurses would be more likely to receive abuse having chosen a caring profession and being predominantly female although men do also experience this type of abuse. It was questioned whether East and North Hertfordshire NHS Trust had acknowledged this concern.

Survivors would need to consider how to safely get to and from work and the Trust was looking at how to help them. Flexibility remained important for survivors. There was some structure in place for the survivor and the Trust was additionally looking at wider safety netting. Managers being curious about the welfare of their team along with other staff helping would also be useful.

It was commented that some people were easier to speak with regarding domestic abuse while others could shut down instead for various reasons. Managers should ensure that staff are able

to speak to them as a routine part of good management. It was accepted that people were not always aware of the possibility of domestic abuse East and North Hertfordshire NHS Trust must ensure that it continues to raise awareness of the possibility of abuse. Also, it took bravery to reveal this story so every opportunity must be used to ensure that a safe space exists to raise awareness of what has taken place. Staff were thanked for undertaking this work and they should let the Board know of anything which can be done to assist.

The Trust Board **RECEIVED** and **NOTED** the Staff Story.

23/030 CHIEF EXECUTIVE'S REPORT

Mr Adam Sewell-Jones reported that the Care Quality Commission (CQC) visited Lister Hospital on 20 and 21 June 2023 and they had been complimentary regarding how staff had received them. During their visit, they had recognised the many challenges relating to emergency care, however, the focus on patient safety from Emergency Department (ED) staff remained exemplary.

Areas of focus by the CQC included patient care during long waits in the ED, dealing with mental health patients faster, improving flow management, discharge improvement programmes, reducing number of patients who are medically optimised and so on. The Maternity Department remained under a warning notice, but staff received complimentary feedback on recent improvements.

There were no clear indications of when the Trust would receive the CQC report, but it was likely to be published after summer. Following publication, the report would be brought before the Board for further discussion.

The five-day junior doctor strike this month is likely to take place. Planning by operational leaders has already commenced, however, there will be an implication in terms of planned care activities. Although, each industrial action means less planned care is cancelled due to the knowledge gained from previous strikes.

The Estates and Facilities day was celebrated last month recognising the vital work done by this department. Excellent work from staff on wards has been observed in terms of the cleaning practices.

2023 is the 75th year since the creation of the NHS and since the HMT Empire Windrush arrived in Britain. Both events marked a significant contribution to both British society and to the NHS as a

whole.

A specialist theatre offering vascular services in Hertfordshire and West Essex will shortly be built at Lister. This is due to open in Spring 2024.

The Virginia Mason Institute (VMI) has been selected to work with the Trust to help develop our quality management system for the next three years. Funding the VMI contract will have to come from internal sources but both the integrated care systems (ICS) and NHS England are very supportive of the appointment. Work will also be carried out to ensure an assessment on cultural readiness.

There may also be a consultants strike this month – the hospital expects to operate under 'Christmas day cover', although discussions continue with the British Medical Association. Staff do not have to advise the Trust whether they plan to work as normal. Safe staffing rotas were being established and concerns regarding how patients were dealt with due to strikes were also being addressed.

The Board **RECEIVED** and **NOTED** the Chief Executive Officer's report.

23/030.1 ELECTIVE CARE NHS ENGLAND LETTER

Mr Sewell-Jones had reported that, despite industrial action, waiting lists have been decreasing between September 2021 and March 2023. Community paediatrics remains a challenge both locally and nationally.

Work with the Virginia Mason Institute has received approval.

Paediatric Audiology - Following the findings at NHS Lothian, diagnostic rates of congenital deafness were reviewed at the Trust in April 2022 by the national team. It was found that rates of diagnosis was lower than expected at East and North Hertfordshire NHS Trust (ENHT). The UK Accreditation Service (UKAS) review had also found problems with the wider paediatric audiology service. Based on this, the service had been paused. A team from Guys and St Thomas' Hospital have been working with us to make the necessary improvements prior to restarting the service.

It was suggested that outpatient follow up reduction could be included in the Integrated Performance Report to ensure monthly reporting.

23/031 BOARD ASSURANCE FRAMEWORK

Mr Stuart Dalton highlighted the two new risks, autonomy and

accountability and digital transformation (both of which have been scored at 16) and asked whether the Board were happy with the way these were being dealt with. The Finance, Planning and Performance Committee were also due to be asked. The question would also be put to the People Committee on 18 July 2023.

The Board **RECEIVED** and **NOTED** the Board Assurance Framework. The Board **AGREED** the ratings of the two new risks.

STRATEGY AND CULTURAL ITEMS

23/032 UNIVERSITY STATUS ANNUAL REPORT

Dr Justin Daniels briefly reported on the Trust / University of Hertfordshire joint partnership. Dr Zoe Aslanpour (Director) and Professor Shahid Khan (Clinical Lead) had attended the Trust Management Group on 1 June 2023 to present their findings.

This has been a successful and productive partnership across many different areas, both clinical and non-clinical. More detail is given in the report.

The University is now looking to establish a medical school, starting with a postgraduate qualification. The plan is to recruit mainly overseas students until permission is granted for UK students. If all goes well, UK based medical students could be recruited from August 2026.

It was suggested that some other areas for cooperation might include linking the Lister Education Centre to the University library and establishing a clinical trials unit at the Lister.

The Board **RECEIVED** and **NOTED** the University status annual report.

23/033 2022/23 STRATEGY DELIVERY REPORT

Mr Kevin O'Hart reported on the progress made last year towards the Trust's eight 22/23 strategic objectives. These objectives were intentionally ambitious reflecting ~~a~~ ENHT's long term vision of an integrated plan and in most cases have been partially but not fully achieved. However, material progress has been made and elements have been refreshed and incorporated into the 23/24 objectives.

The first procedure rooms have been opened at the Lister site and are being used to work through the elective backlog. A learning and evaluation exercise will be introduced to the annual strategic review.

The Board **RECEIVED** and **NOTED** the Strategy Delivery Report.

23/034 STRATEGIC TRANSFORMATION UPDATE

Mr Kevin O'Hart presented the first quarterly update of progress on the 23/24 strategic objectives. The quality objective concentrates on achieving fundamental standards of care on the wards before progressing to the 'excellence standards'. In April, the first cohort of 12 wards started the programme with the other wards starting in July.

The workforce objective is to reduce the cost of our temporary workforce to less that 8% of overall pay. There has been a focus on medical recruitment targeting the top 20 high-cost agency and locum positions with alternative solutions.

The elective recovery objective covers improvements in both outpatients and theatres. Work has continued on developing a new digital patient portal as well as improving contact centre processes. Reducing outpatient appointments and moving patients safely onto 'patient-initiated follow-ups' continues to be rolled out across specialities including ophthalmology

Following the successful establishment of the Hospital at Home programme over the last 18 months, a new integrated heart failure service at home was launched in April, aiming to recruit up to 50 patients by September 2023.

The Board **RECEIVED** and **NOTED** the strategic transformation update.

ASSURANCE AND GOVERNANCE ITEMS

23/035 MATERNITY AND CARE QUALITY COMMISSION PROGRESS

Following the inspection undertaken in October 2023, the CQC rated Maternity services as inadequate.

Six key workstreams were identified including equipment and facilities, infection prevention and control, risk assessment and workforce and training.

An unannounced inspection in June this year recognised the good progress made since the previous inspection and acknowledged that an establishment review for maternity is in progress.

The slight decline in the birth rate and the increase in the caesarean section rate were noted to be important considerations in terms of establishment setting. The current vacancy rate of 10% was noted. It was discussed that this vacancy prominently sits within the clinical midwifery workforce. Many of our current

third year students had opted to stay and will be joining us as newly qualified midwives in October. A longer-term workforce strategy is needed to ensure a sustainable workforce across maternity services.

Digital transformation was raised as an ongoing challenge. A digital solution to electronic patient records continues to be scoped.

Key successes were acknowledged - sustained guideline re compliance of >90% and the launch of the Birmingham Specific Obstetric Triaging System and increased footprint of maternity triage.

In terms of the unannounced inspection, the CQC fed back positive changes with staff keen to share their experience and examples of good practice with the CQC.

The Maternity department previously had a sickness rate of 20% among the consultants. There has been a significant reduction in sickness in the last 3 months. Training compliance for Maternity is above 90%. PROM training is also 90% but it was suggested that there is a need to increase headroom to ensure sustained compliance.

With regards to previous concerns raised through the junior doctors training survey, the level of confidence in support and escalation pathways was noted, alongside other improvements; including better access to supervisors who are recognised as being approachable. There is greater opportunity for staff to share concerns or meet with their supervisors to enable prompt resolution instead of waiting for the survey to express their concerns. It was asked whether this had the necessary traction as staff should be free to voice their opinions. Positive feedback had been given about the response to any cultural incidents and the ability for local resolutions.

The perception is that the relationship between senior clinical midwives and junior doctors can be challenging. It was asked how these relationships could be strengthened. It was suggested that creating a welcoming environment and building relationships from the point of induction would help new doctors to feel welcomed and supported from the outset.

The Board **RECEIVED** and **NOTED** the Maternity and Care Quality Commission Progress Report.

23/036 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) PLAN

Mr Jon Bramall and Ms Margaret-Mary Devaney presented the PSIRF plan which replaced the Serious Incident Framework introduced in 2015 and aimed to improve the learning from patient safety incidents. The PSIRF plan sets out how ENHT will respond to safety incidents over the next 12-18 months. The plan will be less top down, bureaucratic and data driven. It will recognise that humans are fallible and that improving patient safety can only be achieved by systematic changes that are co-designed with patients. It offers a more multidisciplinary and holistic approach to learning from incidents.

The work towards establishing the PSIRF has been happening nationally and we have also been making some local changes to our incident policy. We have started to 'cluster' similar incidents to support more collaborative learning and adopted multidisciplinary 'round table' learning forums for staff to share experience and learning from incidents.

The ENHT patient safety response policy will be developed with wider stakeholders including our ICB, the coroner and social care colleagues. It will be taken to the Quality and Safety Committee and the Board for comment.

It was added that there is more work to be done on the plan including developing measurements and key performance indicators. A feedback mechanism will also be put in place.

The Board was reminded that a PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for the Trust.

The Board **RECEIVED** and **APPROVED** the Patient Safety Incident Response Framework plan before it is shared with the Integrated Care Board (ICB).

23/037 QUALITY ACCOUNT

The Quality Account for 22/23 was presented for approval and sign off in line with NHS requirements. It has been shared with our system partners and our ICB and their feedback has been included. It was suggested that a brief summary of the Quality Account might be prepared to be shared more widely with our community and primary care as was done with our Annual Report last year.

The Board **RECEIVED**, **NOTED** and **APPROVED** the Quality Account.

East and North Hertfordshire NHS Trust

23/038 COMMITTEE TERMS OF REFERENCE CHANGES

Mr Dalton reported that the changes were part of the annual review of Committees. The Charity Trustee Committee would also be reviewed. At the time, there were no changes requested for the People Committee.

The Board **RECEIVED**, **NOTED** and **APPROVED** the Committee Terms of Reference changes.

PERFORMANCE

23/039 INTEGRATED PERFORMANCE REPORT

The IPR had been discussed at Committee level so Mr Martin Armstrong picked out some highlights. Crude mortality rate has dropped back to the pre pandemic level. The 12-month rolling hospital standardised mortality ratio (HSMR) and summary hospital-level mortality indicator (SHMI) levels have increased slightly but the Trust remains well positioned against its peers. Re-admission rates remain relatively stable.

High attendance and higher acuity at A&E together with reduced inpatient discharges resulted in a drop in the 4-hr target to 65%, lower than the national average of 71%. Following an emergency care intensive support team (ECIST) review in May, six new urgent and emergency care (UEC) workstreams have started to improve A&E performance.

The overall vacancy rate is down to 7.8%, with the lowest monthly demand for bank and agency staff in over a year. There are over 260 applicants in the pipeline including 34 doctors and 132 nurses. There is a focus on recruitment of anaesthetists to support the elective recovery programme and reduce waiting list initiatives (WLIs).

Ms Lucy Davies reported that the 62-day cancer target was narrowly missed due to diagnostic delays and industrial action but is on track to recover and the Trust remains one of the best performers in the country. There were still over 500 patients waiting more than 78 weeks for treatment at the end of May, predominantly in community paediatrics.

In terms of finance, month two is on plan but achieving the cost improvement programme this year remains a significant risk.

It was reported that year to date cases of Clostridioides difficile infections remain above trajectory, which has also occurred regionally and nationally. The Infection Prevention and Control team have started a Trust-wide action plan to identify and treat patients more quickly.

The Board **RECEIVED** and **NOTED** the Integrated Performance Report.

23/040 **SYSTEM PERFORMANCE REPORT**

It was suggested that the Chair and CEO of the ICB should be invited to attend the September Board meeting. Their report could be taken early in the meeting after the Staff Story.

Chair to liaise with ICB

Action: The Trust Chair agreed to liaise with the Integrated Care Board to invite them to the meeting.

The Board **RECEIVED** and **NOTED** the System Performance Report.

BOARD COMMITTEE REPORTS:

23/041 **FINANCE, PERFORMANCE AND PLANNING COMMITTEE REPORT TO BOARD**

The Board **RECEIVED** and **NOTED** the summary reports from the Finance, Performance and Planning Committee meetings held on:

30 May 2023

20 June 2023

23/042 **QUALITY AND SAFETY COMMITTEE REPORT TO BOARD**

The Board **RECEIVED** and **NOTED** the summary reports from the Quality and Safety Committee meetings held on:

24 May 2023

28 June 2023

23/043 **AUDIT COMMITTEE REPORT TO BOARD**

The Board **RECEIVED** and **NOTED** the summary reports from the Audit and Risk Committee meetings held on:

17 May 2023

26 June 2023

23/044 **PEOPLE COMMITTEE REPORT TO BOARD**

A summary report for the People Committee had not been provided to the Board.

23/045 **CHARITY TRUSTEE COMMITTEE REPORT TO BOARD**

The Board **RECEIVED** and **NOTED** the summary report of the Charity Trustee Committee meeting held on 5 June 2023

23/046 ANNUAL CYCLE

The Board **RECEIVED** and **NOTED** the latest version of the Annual Cycle.

23/047 ANY OTHER BUSINESS

No other business was raised.

23/048 DATE OF NEXT MEETING

The next meeting of the Trust Board will be on 6 September 2023.

Mrs Ellen Schroder
Trust Chair
July 2023

	Action has slipped
	Action is not yet complete but on track
	Action completed
*	Moved with agreement

Agenda item: 5

EAST AND NORTH HERTFORDSHIRE NHS TRUST
TRUST BOARD ACTIONS LOG TO 6 September 2023

Meeting Date	Minute ref	Issue	Action	Update	Responsibility	Target Date
5 July 2023	23/040	Inviting the Chair and Chief Executive Officer of the ICB to the September meeting.	The Trust Chair to liaise with the Integrated Care Board (ICB) and invite them to the meeting.	The ICB Chair and CEO will attend the board seminar in December as they were not available to attend the September Trust board meeting.	Trust Chair	*December 2023

East and North Hertfordshire NHS Trust

Chief Executive's Report

September 2023

I outline some of the highlights from within the Trust since the last board meeting under our key strategic themes below.

Quality

Firstly, you will have been shocked like me to hear further details emerge following the conviction of the neonatal nurse Lucy Letby. First and foremost this has been a tragedy for those babies and families and our thoughts go out to them. It is right that an inquiry will take place and then that lessons that emerge are both learnt and acted upon.

Later in the agenda you will hear from various directors about the processes in place to manage the risk of any issue of this nature ever occurring within the Trust.

I was lucky enough to spend some time with the neonatal team here, who provide fantastic care for some of our most vulnerable patients. This has been understandably extremely painful for them but parents have been grateful for their openness as well as their compassionate and expert care.

We received an inspection visit by the Care Quality Commission (CQC) between the 2nd and 3rd of August to complete the well led element of their assessment. We expect to shortly receive a draft report following the full inspection of core services at the Lister Hospital.

Attached to my report is the record of the verbal feedback received following the visit.

Thriving people

Industrial action has continued to take place over the summer. The next consultant strikes are planned for 19 and 20 September and the British Medical Association (BMA) are balloting junior doctors for further industrial action with a closing date of 31st August.

Staff have continued to respond to support colleagues taking such action. Whilst emergency and urgent services have remained in place, the impact on planned services sadly has meant further cancellations and delays to patients receiving appointments and surgery.

Congratulations to the following teams and individuals who have been shortlisted in this year's National BAME Health and Care Awards. The awards were set up to create an opportunity to ensure recognition of staff who show ambition and vision in securing access and service improvements for BAME communities.

- Dede Thorpe is shortlisted for BAME Midwife of the Year
- The Continuity Midwifery Team are shortlisted for Outstanding Achievement of the Year
- Helen Campbell has been shortlisted for Ally of the Year

The awards will be held on Thursday 28th September.

In addition six colleagues have been shortlisted in the Nursing Times Workforce Awards.
Our finalists are:

- Lyn Thomas, manager of the year (non-clinical)
- Mariam Tolentino, nurse manager of the year
- Jerome Alagao, practice educator of the year
- Akeem Fernandez, preceptor of the year
- Jethro Conde, overseas nurse of the year
- Meldrick Magsino, overseas nurse of the year

Winners will be announced at the awards ceremony on Tuesday 21st November.

Seamless services

A new Integrated Heart Failure Service has been developed by colleagues across the East and North Hertfordshire Health and Care Partnership.

There are currently more than 4,000 people who are registered with heart failure in East and North Hertfordshire, although the actual figure is estimated to be as high as 7,000.

The service will enable patients with heart failure to be monitored closer to home and benefit from earlier identification, diagnosis and management of their condition. It will include access (where required) to a consultant cardiologist in the Trust, as well as specialist heart failure nurses working closely with community nurses, hospices and primary care colleagues.

Urgent and Emergency Care (UEC) pathways within the Trust support close to 200,000 patients per year. Extended waits in these pathways present challenges to patients and staff alike. The Trust has in place a UEC Improvement Plan which includes the opening of urgent treatment centres (UTCs) for children and adults on the Lister Hospital site, a new Surgical Assessment Unit and Same Day Emergency Care Unit, a workforce review in the Emergency Departments and changes to the tower block bed allocations following refurbishment work.

Continuous Improvement

Our new digital Patient Hub is now live for our Orthotics patients. Patients that use this service can see information about their outpatient appointments, including letters and other useful information, accessible by smartphone, tablet or computer.

Whenever we make an orthotics outpatient appointment or make a change to an existing appointment, we will send a text message with links to the relevant information on a Patient Hub account. Patients will be able to use the service to check appointments and receive and download appointment letters and other useful information, such as leaflets about their condition, maps to explain where to come for appointments or questionnaires about symptoms and medical history.

Using this service is optional, and patients will always be able to have printed letters and information posted to them at home.

The digital Patient Hub is being trialled for orthotics patients and will be rolled out across most outpatient services and clinics at our hospitals in the coming months.

Work has now commenced with our improvement partner, the Virginia Mason Institute from Seattle. Members of their team will be visiting the Trust to meet with a large number of staff during September to undertake a ‘cultural assessment’ and the programme will officially launch on October 2nd when we welcome Dr Gary Kaplan, the former CEO of the Virginia Mason Medical Centre, to the Trust to share his experience of implementing and developing their quality management system.

Adam Sewell-Jones
Chief Executive

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Our reference: RWH

Adam Sewell-Jones
East and North Hertfordshire NHS Trust
Trust Headquarters
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Date: 07 August 2023

CQC Reference Number: INS2-15363752921

Dear Adam Sewell-Jones

Re: CQC inspection of East and North Hertfordshire NHS Trust

Following your feedback meeting with myself (Hazel Roberts – CQC Deputy Director of Operations), Antoinette Smith (CQC - Deputy Director of Operations), Emma Schofield (CQC – Operations Manager) and Sarah Connery (CQC – Specialist Advisor and Senior Executive Reviewer) on 3 August 2023. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Justin Daniels (Chief Medical Director) and Theresa Murphy (Chief Nursing Officer) at the feedback meeting. It also contains details that were not shared at the verbal feedback session, but on review of some of our evidence and notes we feel are important for us to share with you.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back around initial findings and provides you with a basis to start considering what action may be needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied into this letter.

An overview of our feedback

The feedback to you is:

Overall, we want to thank you and your teams for the welcome we received and for accommodating us despite the challenges of service delivery and on-going industrial action.

What we found

The leadership team is a mixture of experience with a number of established executives in post and new senior appointments in the last 18 months. The conversations we had with leaders demonstrated that this combination has allowed the organisation to introduce 'fresh eyes' and new ideas, which is welcomed by senior leaders.

There is a board development programme in place and conversations that we had with various leaders demonstrated that the culture is moving towards a high challenge and high support culture to strengthen assurance processes. We also received variable feedback about executive leadership visibility and engagement, and would recommend the Board instigating a programme, to ensure no sites or services are inadvertently overlooked.

We found that the culture within the leadership team was of openness and transparency. Leaders that we spoke with told us about what they were proud of and about their challenges and the areas that still needed improving. Areas for improvement included:

- Improving digital capability – this has impacted on staff and patient experience in areas such as gastroenterology and the implementation of an effective electronic patient record. There is a plan in place to address this which is being led by the Chief Information Officer.
- Strengthening the governance systems in areas of accountability and ensuring that information for decision-making is of sufficient quality to enable effective challenge.
- Improving the access and flow through the hospital by improving relationships internally and working collaboratively with system partners in mental health care, primary care and social care.

At divisional level we found that the triumvirate leadership teams were working hard to develop strategies and build working relationships. We found that there were examples of strong clinical leadership in all of the divisions, including women's and children, maternity services and cancer services.

The trust has made a number of achievements in areas such as robotics and have engaged with Virginia Mason Institute to develop a culture of continuous improvement. We heard from leaders at all levels that there is a strong desire to have more autonomy at divisional level to engage with innovation; however, some leaders felt that there was still a sense of 'grip and control' where there could be more financial autonomy to help make improvements to quality and safety.

The trust appears to have high levels of engagement and is committed to receiving a diverse range of views from public and staff and to drive forward the co-production

agenda in all services. The patient stories at divisional meetings were having a positive impact on staff culture. On review of information, we found that the patient voice/experience did not appear to feature as strongly as it could on the balance scorecard and perhaps this needs to be strengthened in the performance framework.

Whilst the onsite well-led inspection was largely a positive experience, and we heard many positive examples of how the leadership team are working with staff and patients to drive necessary improvements, it is important to note that the overall well-led also considers the findings from the core service inspections and the patients' experience of quality and equal access.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Amba Murdamootoo at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Hazel Roberts

Deputy Director of Operations

c.c. Chair of Trust
NHS England representative
CQC regional communications manager

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	9
Report title	Workforce Race Equality Standard Report (WRES) Workforce Disability Equality Standard report (WDES)			**Meeting Date**	6 September 2023
Presenter	Thomas Pounds, Chief People Officer				
Author	Amanda Harcus, Deputy Chief People Officer				
Responsible Director	Thomas Pounds, Chief People Officer			**Approval Date**	23 August 23
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☒
	Discussion	☐	**Decision**		☐

Report Summary:

The purpose of the WRES and WDES reports are to:

1. Provide organisation Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data, including a brief analysis and the findings which highlight areas for improvement.
2. Highlight ENHT progress on equality and inclusion at local and system level.
3. Set out recommendations as to priority areas which align with NHS People Plan, ENHT Vision and People Team strategic priorities, to deliver and drive forward the equity and inclusion agenda.

The committee is asked to consider and note the content and approve the publication of the same on the Trust and national websites.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

Poor staff experience could increase negative staff survey results, higher turnover, sickness absence rates and on-going recruitment costs.
The culture and context of the organisation leave the workforce insufficiently empowered and motivated, impacting the trust's ability to deliver improvements and transformation and enable people to feel proud to work here.

Risk: *Please specify any links to the BAF or Risk Register*

Indirect impact on BAF Strategic risks:
1 Workforce requirements
4 Workforce shortages and skills mix
5 Culture and leadership
6 Engagement and listening

Report previously considered by & date(s):

September 2022

Recommendation	The Board/Committee is asked to 1. Approve and sign off WRES data 2. Review, discuss and approve the high priority areas for improvement

To be trusted to provide consistently outstanding care and exemplary service

July 2023 WDES Report

East and North Hertfordshire NHS Trust

Workforce Disability Equality Standard (WDES) Report 2023

1. Introduction

In 2019 NHS England, with its partners, prioritised its commitment to tackling discrimination and the Workforce Disability Equality Standard (WDES) came into force. It contains 10 metrics to compare the experiences of Disabled and non-Disabled staff, which is then used to implement action plans. The Trust is required to submit the data set using the national format.

In 2022/23 we identified a number of high priority areas for improvement as part of our ED&I objectives designed to drive positive change towards equity and inclusion underpinned by strategic priorities from People Directorate as well as Trust mission, strategic themes, and vision for 2030 this report updates our progress on these priorities.

2. WDES Metrics and context

The 10 metrics of the WDES are set out here for clarity and context of the report:

1. % of Disabled staff in the Workforce
2. Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.
3. Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance
4. Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse
5. (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6. (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC): Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
7. (Relates to Q4b in the NHS Staff Survey): Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
8. (Relates to Q30b in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC):Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.
9. (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey); Questions are related to staff with Long Term Conditions (LTC)The staff engagement score for Disabled staff, compared to non-disabled staff.
10. The organisation’s board voting membership versus its organisation’s overall workforce

3. WDES Metrics and performance

Our performance overall in our WDES metrics requires continued improvement and focus, we have refreshed our staff network chairs and executive sponsors and currently collaboratively agreeing focussed action plans for delivery over the coming two years, an updated overall EDI action plan will come to committee in September 2023 for approval.

The WDES metrics data below shows our performance since 2020/21. Over the last 18 months focus has been in place, encouraging staff to update their personal equality data and whilst representation has improved, it is likely this is linked to improved declarations and more accurate data in place and that staff are feeling more secure in declaring a disability in the workplace, we recognise there is more work to do overall around inclusivity in our workforce.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT**	**ENHT**	**ENHT**	**ENHT WDES Progress in comparison to last year**	**National WDES 2020/2021**
		2020/2021	**2021/2022**	**2022/2023**		
Metric 1 – % of Disabled staff in the Workforce	**Cluster 1: AfC Bands under 1, 1, 2, 3 and 4**	Non-Clinical = 4.4% Clinical = 3.2%	Non-Clinical = 4.0% Clinical = 3.0%	Non-Clinical = 4.8% Clinical = 3.2%	Improvement	3.7%
	Cluster 2: AfC Bands 5, 6 and 7	Non-Clinical = 3.0% Clinical = 2.2%	Non-Clinical = 4.1% Clinical = 2.0%	Non-Clinical = 4.9% Clinical = 2.8%	Improvement	
	Cluster 3: AfC Bands 8a and 8b	Non-Clinical = 0% Clinical = 0.0%	Non-Clinical = 2.2% Clinical = 1.0%	Non-Clinical = 3.0% Clinical = 1.9%	Improvement	
	Cluster 4: AfC Bands 8c, 8d, 9 and VSM	Non-Clinical = 0% Clinical = 0%	Non-Clinical = 0% Clinical = 0%	Non-Clinical = 1.4% Clinical = 3.0%	Improvement	
	Cluster 5: Medical and Dental staff, consultants	Non-Clinical = n/a Clinical = 0.0%	Non-Clinical = n/a Clinical = 0.0%	Non-Clinical = n/a Clinical = 0.25%	Improvement	
	Cluster 6: Medical and Dental staff, non-consultant career grades	Non-Clinical = n/a Clinical = 0.51%	Non-Clinical = n/a Clinical = 0.48%	Non-Clinical = n/a Clinical = 1.52%	Improvement	
	Cluster 7: Medical and Dental staff, trainee grades	Non-Clinical = n/a Clinical = 0.51%	Non-Clinical = n/a Clinical = 1.46%	Non-Clinical = n/a Clinical = 0.75%	n.b: The EoE Deanery is responsible for the recruitment and placement of Doctors in training	
Metric 2 - Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		1.19	1.6	1.23	Improvement	1.11
Metric 3 - Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance		0	0	0	**No change**	1.94

Metric 2 demonstrates that work around inclusive recruitment is beginning to show progress in our workforce representation, and we are using inclusive language and encouraging more people with protected characteristics to work with ENHT.

Table below shows the national data taken form the 2022 staff survey benchmark average, demonstrated that metric 4 has further work is required relating to staff experiencing bullying and harassment in the workplace. Our staff survey overall showed an increase in declarations in this area, directly related to a higher number of incidents (physical assault and/or verbal abuse) from the public toward staff as well as an increase in staff reporting staff and manager inappropriate behaviour incidents.

This is a positive step and an important part of enabling change, the first step creating confidence to speak up, the next is staff telling us and us dealing with and addressing inappropriate workplace behaviours and how we are handling complaints continued to improve, both in time taken and outcomes and through

facilitated conversations and formal action and the work of our FTSU. It is predicted this figure may rise again in the 2023 staff survey results ahead of seeing improvements in future years.

	East & North Herts (ENHT) WDES Data					
Workforce Disability Equality Standard (WDES) Indicators		**ENHT** 2020/2021	**ENHT** 2021/2022	**ENHT** 2022/2023	**ENHT WDES Progress in comparison to last year**	**National WDES 2020/2021**
Metric 4 (Relates to Q14a-d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:	Patients/Service users, their relatives or other members of the public	With LTC = 35.9% Without LTC = 25.5%	With LTC = 38.4% Without LTC = 30.5%	With LTC = 39% Without LTC = 30.4%	Requires Improvement	33.0%
	Managers	With LTC = 24.4% Without LTC = 14.0%	With LTC = 21.6% Without LTC = 12.9%	With LTC = 22.3% Without LTC = 12.3%	Requires Improvement	17.1%
	Other colleagues	With LTC = 26.1% Without LTC = 18.8%	With LTC = 32.4% Without LTC = 19.8%	With LTC = 32.6% Without LTC = 20.5%	Requires Improvement	26.9%
	Percentage of Disabled staff saying they or a colleague reported the harassment/bullying or abuse.	With LTC = 41.0% Without LTC = 41.9%	With LTC = 47.2% Without LTC = 46.0%	With LTC = 49.7% Without LTC = 47.1%	Improvement	48.4%
Metric 5 (Relates to Q15 in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		With LTC = 46.0% Without LTC = 80.9%	With LTC = 42.1% Without LTC = 55.6%	With LTC = 46.7% Without LTC = 54.3%	Improvement	51.4%

Metric 5 above demonstrates our inclusive recruitment practices of anonymised and positive action is taking effect, however more work is required for ENHT to meet the national WDES survey

In metric 6 below our education programme and voice of our staff network, which has enabled us to share lived experiences all contribute to the 5% improvement of this metric, e.g. Civility saves lives, staff values charter and healthy teams rhythm work, however, metric 7 confirms that more ongoing work to recognise the contribution of our disabled colleagues work to be valued equally or above has to continue and the action plan summary outlines current and new work happening in 2023/24.

Workforce Disability Equality Standard (WDES) Indicators		ENHT 2020/2021	ENHT 2021/2022	ENHT 2022/2023	ENHT WDES Progress in comparison to last year	National WDES 2020/2021	
Metric 6 (Relates to Q11e in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		With LTC = 38.4% Without LTC = 26.2%	With LTC = 38.2% Without LTC = 26.2%	With LTC = 33.2% Without LTC = 22.3%	Improvement	30.0%	Taken form 22 staff survey benchmark average
Metric 7 (Relates to Q4b in the NHS Staff Survey) Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		With LTC = 32.4% Without LTC = 48.4%	With LTC = 31.7% Without LTC = 45.7%	With LTC = 28.3% Without LTC = 43.0%	Requires Improvement	32.5%	
Metric 8 (Relates to Q30b in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.		no data available, terminology of question changed in 2022		71.7%	-	71.8%	

In relation to metric 8 above, by October 2023 a clear process flow will become available, this follows work to pilot and map out the current end to end access to work process and seek to unblock delays and approvals, in parallel we must establish how many adjustments could be required in the current workforce, recognising some of our staff may benefit from seeking access to work assistance and may not be aware, managers can also benefit from education around this and an accompanying communication campaign will launch at the same time, this should lead to improved metric performance in subsequent years.

The table below shows metric 9 remained static and cumulatively reflects a status quo which will improve over time as we work on actions from metrics 4, 6 and 8 above. Metric 10 has opportunity to improve with vacancies arising at Board level, and plans to introduce a shadow board in 2024.

Workforce Disability Equality Standard (WDES) Indicators		ENHT 2020/2021	ENHT 2021/2022	ENHT 2022/2023	ENHT WDES Progress in comparison to last year	National WDES 2020/2021	
Metric 9a (Relates to the staff engagement theme of the NHS Staff Survey, made up from Q2a, Q2b, Q2c, Q3c, Q3d, Q3f, Q23a, Q23c and Q23d in the NHS Staff Survey) Questions are related to staff with Long Term Conditions (LTC) The staff engagement score for Disabled staff, compared to non-disabled staff.		With LTC = 6.5 Without LTC = 7.0	With LTC = 6.26 Without LTC = 6.98	With LTC = 6.26 Without LTC = 6.84	No change	6.4	Taken form 22 staff survey benchmark average
Metric 10 - The organisation's board voting membership versus its organisation's overall workforce	Voting membership of the board	0.0%	0.0%	0%	No change, but requires improvement	3.7%	
	Non-voting membership of the board	0.0%	0.0%	0%			
	Executive membership of the board.	0.0%	0.0%	0%			
	Non-exec membership of the board.	0.0%	0.0%	0%			

The action plan from 2021/22 outlined a programme of work against the WDES and the updates on this action plan are listed below

Update on WDES action plan 2021/22

Objective	Actions	Metrics	Updates at July 2023	RAG rating
Career progression for staff with disabilities To support the progression of staff with disabilities to ensure representation across the whole workforce and achieve year on year increase in percentage number of staff with disabilities progressing within agenda for change bands.	ICS Inclusive Career Development Programme for BAME and Disabled members of staff – first cohort Sep 2022 '**Share your story' / Case studies** of disabled members of staff with across different grades/professions and publicised widely	**WDES 1** Percentage of staff in AFC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with percentage of staff in the overall workforce	As, part of deaf awareness week we shared staff stories of disabled staff and what support is available via the leadership forum. A wider, regular rhythm of stories in trust news or on the Knowledge Centre	Green Green
	Develop Career Development Programme with focus on disabled members of staff linking with Talent Management and grow conversations - **WDES Innovation funding application** Embed Quality Improvement methodology with aim of driving improvement	**WDES 5** Percentage of Disabled staff compared to non-disabled staff believing that their organisation provides equal opportunities for career progression or promotion.	Via the 2022 staff survey the score on this metric has been improved from 42.1% to 46.7%. However, in reality despite having staff on initial cohort's the promotion of the programmes due to review of internal capacity has slowed progress. More work needs to be done in promoting inclusive career development programme for staff in the system between bands 2/4 and bands 5/7	Green Green – Amber

Reasonable Adjustments To achieve year on year increase in percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Review the process, how the fund is accessed and the marketing of the scheme to build awareness and utilisation. Share summary take-up report with equality & Inclusion committee Targeting staff that may need reasonable adjustment fund support e.g., cohort of staff who were Shielding. Engage with relevant stakeholders and discuss implementation of training such as Public Sector Equality Duty. Creating an ambition to become Disability Confident Leader by 2023- ensuring initiative such as Project Search and other schemes are being embedded in our organisation when appropriately.	**WDES 3** Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure **WDES 6** Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. **WDES 8** Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work **WDES 9** The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	The wider work around the reasonable adjustment passport has stalled due to network chair leaving, will be recommenced in August 2023 Project search is planned for 2024 September start. Exec sponsor is Lucy Davies and there is a core working group linked in with ICS work. Next step is for project search to update on the education partner and for expression of interest forms to be sent out to teams to host a placement. We, are also waiting on a new EDI lead to ensure the process is all running smoothly on the ground. The score around reasonable adjustments from the staff survey is slightly below the national acute average Engagement score has stayed the same compared to last year	Amber – Green Green Amber – Green Green Amber – Green Amber

Culture Change **To secure an increase in the number of Staff reporting disability on ESR** and narrowing the gap in their reported experience of working at ENHT compared to all staff by third quarter of year 2023 (measured by staff survey & ESR Data))	Disability Equality Awareness Training to be incorporated into Recruitment & Selection training for hiring Managers Understand impact of COVID-19 on disabled members of staff by working Wellbeing team to guide our actions/response. To drive the quality of the inclusive recruitment and selection process To complete the review of recruitment & selection process with 3 priority areas identified as follows: a) Train more Inclusion Ambassadors. b) Recruitment & Selection Training for hiring managers. c) Advertising job opportunities to the wider communities d) assurance on Reasonable adjustment and Guarantee interview scheme	***WDES 1** **WDES 2** Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts. ***WDES 9**	There has been an increase in FSTU representation and wider work in the system around making the interview process more inclusive more inclusive for applicants, with a slight change in our wording on trac to be in line with the system. More work needs to be done around disability equality awareness training and reviewing the guaranteed interview scheme	Green Amber – Green

Appreciation & Recognition To appreciate and value disabled members of staff	Health, wellbeing, and diversity conversations into the appraisal process to empower and support staff. Continued support for staff returning from long term sickness Launch **'Ability Not Disability'** campaign and start with teams taking part in education about matters that affects disabled members of staff Celebrating Difference Events such as Day of Persons with a Disability	**WDES 7** Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work ***WDES 9**	Via staff survey this metric has decreased by 3% Ability not disability campaign to be scoped and launched. Stalls for disability history month and international day of disabled people.	Amber Red Green
Dignity at Work The experience of bullying, harassment, and abuse within the workplace	Reviewing relevant work-related Policies (Dignity at work, Disciplinary, Reasonable adjustment) Finalise and Launch the Use of **Disability Passport** embedded/recorded by Health at Work Team Process and ESR by December 2022.	***WDES 4** **a)** Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues **b)** Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced	Increase via staff survey in staff reporting bullying or harassment and very slight increase in the instances of bullying and harassment	Amber – Green

		harassment, bullying or abuse at work, they or a colleague reported it.		
Inclusive Recruitment Practice Ensuring fairness in recruitment and selection process with attention given to employee life cycle.	Continuing to strengthen governance of the Equality and Inclusion process with a focus on strengthening our leadership narrative, embedding delivery within sites and corporate functions, and setting aspirational and achievable annual goals that we can strive to achieve. Disabled Members of Staff Network Chair and ED&I team continue to link and presenting on Staff Experience Groups & People Committee	***WDES 1** ***WDES 2** ***WDES 5** **WDES 10** Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated • By voting membership of the Board By Executive membership of the Board	We have seen green shoots with executive backing for project search and work around the ICS career development programme We now have new co-chairs in place and are looking to create a mission statement for the network and action plans by Sept/October 2023.	Green Green

	Working with Regional and National teams on new initiatives and opportunities for Key areas that we aspire to develop.			
Equitable representation in entering Capability process To enable proportionate representation of Disabled staff compared to non-disabled staff entering the formal capability process.	Targeting staff who may need Reasonable Adjustments Fund support Deep dive into data to identify any themes relating to poorer experiences and outcomes for disabled members of staff. A review related policies and procedures through Equality, Diversity & Inclusion lens to include the lived experiences of disabled members of staff.	***WDES 3**	This work is a priority to scope and commence before end of 2023/24 financial year	Amber

4. **Recommendations**

ENHT has established a clear and honest evaluation of its WDES, with small and sustained improvements and it is recommended that the action plan above continues to deliver and be evaluated in collaboration with the wider Healthy Culture team, people partners and staff network with the disability staff network bringing forward their mission statement and action plan of further work identified into this action plan, accepting that work will need to be continued into 2024/2025 to improve staff engagement and experience of staff with disabilities.

July 2023
WRES Report

NHS
East and North Hertfordshire
NHS Trust

Workforce Race Equality Standard (WRES) Report 2023

1. Introduction and Scope

Since its introduction in 2015, NHS England's Workforce Race Equality Standards (WRES) programme has been providing direction and tailored support to the NHS, enabling organisations to continuously improve their performance. The WRES has required NHS trusts to annually self-assess against nine indicators of workplace experience and opportunity in relation to race, and to develop and implement robust action planning for improvement.

This interim report focusses on ENHT returns as national and regional data is unavailable at this time, an updated, fuller version of the report will become available once the national and regional data sets are published to us in early Autumn.

ENHT has committed to making anti-racism a reality[1], incorporating respect, dignity and human rights, and by ensuring equitable opportunities free from discrimination for people with protected characteristics as defined by the Equality Act 2010.

ENHT is committed to becoming a leading organisation in promoting equality, diversity, and inclusion in Hertfordshire, by creating a place where every person in our organisation is responsible for enabling an environment which is supportive, fair, and free from discrimination.

This report seeks to understand trends and patterns of inequality and outlines detailed information about our Black, Asian, and Minority Ethnic (BAME) staff, covering the period April 2022 to March 2023, and documents our progress, continuing work, and actions still to deliver equity in relation to the national NHS Workforce Race Equality Standard (WRES).

2. Context

The WRES contains nine indicators covering workforce data, national NHS Staff Survey results and Trust Board composition as follows:

1. Percentage of staff in each of the NHS pay bands 1-9, plus those on Medical & Dental and
   Very Senior Managers contracts (including Executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process
4. Relative likelihood of staff accessing non-mandatory training and CPD
5. Percentage staff experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months (from NHS Annual Staff Survey)
6. Percentage staff experiencing harassment, bullying or abuse from staff in the last 12 months (from NHS Annual Staff Survey)
7. Percentage staff believing that the organisation provides equal opportunities for career progression or promotion (from NHS Annual Staff Survey)
8. Percentage staff having personally experienced discrimination at work from manager, team leader, or other colleagues in the last 12 months (from NHS Annual Staff Survey)
9. Percentage difference between the organisations' Board voting membership and its overall workforce.

All work undertaken in 2022/23 is underpinned by the People Strategy four pillars (Work, Grow, Thrive & Care together) and by working together through and with our staff diversity networks, we continue to ensure our staff networks flourish and we continue to champion the principles of

[1] Making anti-racism a reality, East of England Race Strategy 2021 (Appendix 1)

intersectionality, whilst continuing delivery of the equity and inclusion agenda. As opportunities arise at Board and senior level, we will increase diversity. Our freedom to speak up guardian work and people policy reviews continue to support and enable staff to speak up about their experiences and to confidentially raise concerns to be addressed and resolved.

3. Our priority areas of focus 2022/23

From our 2022 WRES report the following key areas of focus were identified for the 2022/23 period:

1. Consistently improve our standing on the likelihood of BAME staff entering formal disciplinary processes compared to white staff
2. Ensuring equity of access to development opportunities
3. Increasing diversity at senior and board level roles.
4. Interventions to debias local policy and procedures,
5. Co-create equitable, inclusive environments and recognise and appreciate differences through cultural change approaches

The national WRES team identified three top priorities for ENHT to focus on:

High priority areas for improvement within the Trust (to a maximum of three):
Indicator 9: Board representation (overall, voting members, and executive members)
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months against BME staff
Indicator 6: harassment, bullying or abuse from staff in last 12 months against BME staff

4. Progress:

We have seen improvements in 1 and 2 above and the narrative is contained in section 4c-f below, there is good progress however there is more to achieve in both areas. We recognise in priority 3 above, that there is significant work to continue to increase BAME diversity at board and senior levels, many improvements have been achieved in inclusive recruitment and targeted positive action campaigns are supporting us improve.

In relation to 4 above, a range of programmes have taken place including cultural intelligence development with the Board and the FTSU Guardian, continues to build relations and create psychological safe spaces for staff to speak up whilst encouraging and empowering staff to use our policies and processes to raise matters formally, where informal approaches are unsuccessful. The people policies have been updated, with a clear Speak Up Policy launching in July 2023. Further work is planned to redevelop core people policies and embed restorative justice practices appropriately within policies such as grievance and disciplinary and demystifying language in these policies is key throughout 2023/24.

For 5 above we continue to triangulate staff survey results, complaints, and reported incidents identify teams where cultural change approaches are needed and we have provided a range of interventions and support to improve these areas an example – significant improvements in People Team staff survey outcomes. In the last year we have delivered extensive workshops on civility saves lives; redesigned and launched our ENHT values and team workshops where team charters emerge on healthy behaviour and bring the values to life, healthy leadership programme, team talks on staff survey results and actions developed and owned locally. Our staff network events both celebrate and challenge us in this space.

Two of the three nationally defined priorities have small improvements however representation at Board and senior level has more to achieve and deliver.

The 2022 WRES report outlined a comprehensive delivery work plan and the above demonstrates delivery of some of this work and the deliverables for 2023 – 2024 are outlined in the section 7 of this interim report.

5. Current Workforce Race Equality Standard (WRES)

a. ENHT data from 2019/20 to 2022/23 is shown in the table below and narrative for ENHT 2023-2025 is set out **in 4c-g** below.
b. WRES comparison regional and national data 2022 is the most up to date currently available

Workforce Race Equality Standard (WRES) Indicators	East & North Herts (ENHT) WRES Data						WRES Comparison to Regional & National Data	
	Staff	ENHT 2019/2020	ENHT 2020/2021	ENHT 2021/2022	ENHT 2022/2023	ENHT WRES Progress in comparison to last year	East of England WRES 2021/2022	National WRES 2021/2022
WRES 1 – Overall workforce % by Ethnicity	White	62.1%	59.6%	56.7%	55.2%	Increase in Workforce Diversity	69.9%	71.3%
	BAME	31.9%	32.6%	34.5%	37.7%		25.3%	24.2%
	Unknown	6.0%	7.7%	8.8%	7.1%	Improvement	4.8%	4.5%
WRES 2 - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff		1.57	1.32	1.39	1.34	Improvement	1.96	1.54
WRES 3 - Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff		1.44	2.25	1.41	1.47	More work to be done	1.11	1.14
WRES 4 - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff		1.35	1.22	1.37	0.86	Improvement	1.01	1.12
WRES 5 - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives, or the public in last 12 months		BAME 29.6%	BAME 30.6% White 25.9%	BAME 34.6% White 30.4%	BAME 32.2% White 32.2%	Improvement	BAME 30.6% White 28.1%	BAME 29.2% White 27.0%
WRES 6 - Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months		BAME 31.2%	BAME 32.7% White 25.1%	BAME 31.1% White 26.5%	BAME 30.8% White 26.5%	Improvement	BAME 27.6% White 24.7%	BAME 27.6% White 22.5%
WRES 7 – Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion		BAME 76.5%	BAME 69.9% White 83.8%	BAME 49.2% White 55.0%	BAME 50.2% White 54.7%	Improvement	BAME 56.8% White 45.5%	BAME 44.4% White 58.7%
WRES 8 - Percentage of BAME staff personally experienced discrimination at work from Manager/team leader/other colleagues		BAME 15.9%	BAME 19.6% White 7.2%	BAME 16.8% White 7.4%	BAME 15.8% White 8.9%	Improvement	BAME 17.8% White 7.7%	BAME 17.0% White 6.8%
WRES 9 - Percentage of voting members of the Board representation by ethnicity	White	100.0%	100.0%	91.7%	100%	More work to be done	-	-

c. WRES Data Key Findings

The overall representation of minority ethnic staff is 37.7% and has continued to increase year on year, however when analysing the data further this representation is varied across different staff professions: health care sciences, nursing & midwifery and scientific and technical roles are at or above 37%; allied health professionals sits at 34% whereas admin and clerical roles have 18% representation.

It remains the case that all data sets show better representation in lower band roles, with decreasing representation in more senior roles across all staffing groups. In the last 12 months changes in board and VSM roles has impacted the level of representation in relation to WRES, though it should be noted that both sets of groups contain other protected equality characteristics. A particular current opportunity exists to attract and encourage BAME candidates to apply to support ENHT increasing board representation following the recent resignation of the current Trust Board chair.

d. WRES Indicators 1-4

White staff are 1.34 times (approx. 6.5%) more likely to be appointed from shortlisting, compared to minority ethnic staff, however this gap continued to close slightly compared last year. The data shows more minority ethnic staff are applying for roles and being successful at shortlisting stage compared to three years ago, demonstrating our minority ethnic staff are keen to apply for roles, yet not as successful in securing senior roles, work continues to engage development programmes to support the gap, and we have also introduced an ICS-wide agreed item on all job descriptions setting out behaviours required around equality, diversity and inclusion alongside an inclusivity commitment statement and clear essential criteria on diversity and inclusion, tailored to band of role. Analysis on success of development programmes will happen in due course and be available in the wider update to board in Autumn.

The Trust saw a spike in 20/21 on likelihood of minority ethnic staff experiencing formal disciplinary procedures, however, the 2023 data shows a slight increase this year. We continue to utilise a checklist introduced to determine whether any disciplinary case, regardless of ethnicity, has merit to progress to formal stages. Other work continues to better understand the processes and behaviours between managers and staff by supporting managers and staff explore and resolve tension, conflict through psychological safe facilitated conversations.

The relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff metric has moved significantly from 1.37 in 2021/22 to 0.86 in 2022/23, this directly reflects work undertaken to increase the importance of development for all and focus on ensuring CPD opportunities and apprenticeships are promoted across the organisation and more promotion of opportunities through staff networks and other informal channels e.g., email cascades of course places.

e. WRES Indicators 5-8

We have seen an improvement and decrease of 21% of BAME staff saying they experience discrimination at work from a manager / team leader or other colleagues. The metrics of indicators five to eight are represented in the staff survey results, the 2022 staff survey results showed an

increase in staff completing by 5% and within this more are sharing their experiences and whilst our averages decreased the domains have changed, with morale and we are always learning becoming areas requiring focus. Work has continued around speaking up, FTSU and safety of staff at work throughout 2022/23.

Work will continue to educate our staff and communities on incivility and its impact. Our civility saves lives film is being used externally and we refreshed our Trust values encouraging and building confidence for all our staff to positively challenge and call-in uncivil behaviour. As we increase psychological safety in the workplace, this in turn will see staff survey results show a decline initially and then increase staff's ability to positively advocate for others.

f. Model Employer

Model Employer targets were set in 2018 over a 10-year period through to 2028 and the NHS People Plan 2020 set an ambition to increase senior leader representation by 2025 to equate to either the organisational or community percentage, whichever is highest.

In ENHT the overall representation of BAME workforce currently sits at 37.5% as of March 23 compared to 19.2% in the Hertfordshire County.

Progress is being made with greater proportionate representation at band 8a and above, however, there is less representation at the most senior levels and model employer targets are not being met for all grades. Transparency is a key step towards achieving our model employer goals and we need to proactively be more inclusive considering our structural and procedures barriers requiring everyone's input. This additionally involves looking beyond operational changes and enabling cultural and transformational changes.

ENHT will improve on its mission of providing high quality, compassionate care to its community where it represents both people it employs at all levels and the population it serves.

The tables below show targets and our data as at April 2023 and progress against targets:

Model employer targets set over 10 years

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Band 8a	29	31	33	36	38	40	42	44	46	49	51
Band 8b	11	12	12	13	13	14	15	15	16	16	17
Band 8c	12	12	12	12	12	12	12	12	12	12	12
Band 8d	0	1	1	2	2	3	3	4	5	5	6
Band 9	1	1	1	2	2	2	2	2	2	3	3
VSM	0	1	1	2	3	4	4	5	6	6	7

*** Please note error on colour of progress showing VSM below should be red – 2.*

Year on year comparison (from band 5)

	Sep-20	Sep-21	Sep-22	Mar-23	Movement from Sept 22
Band 5	525	579	646	702	56
Band 6	307	317	374	415	41
Band 7	145	153	166	192	26
Band 8A	38	46	50	57	7
Band 8B	18	19	19	18	-1
Band 8C	11	11	10	10	0
Band 8D	5	5	8	8	0
Band 9	1	1	1	1	0
VSM	0	2	0	0	0
Grand Total	1050	1133	1274	1402	129

Performance against target

Row Labels	BAME	Model employer targets	Target met?
Band 8A	57	40	Y
Band 8B	18	14	Y
Band 8C	10	12	N
Band 8D	8	3	Y
Band 9	1	2	N
Trust Pay	0	4	N
Grand Total	94	75	50%

The tables demonstrate in March 2023 we meet and exceeded set targets across grades 8a; 8b and 8d; however, more work to do across Band 8c, 9 and VSM on representation.

There are real opportunities for the Trust with the announcement of the current Trust Chair stepping down and where other board roles tenures are due to expire in the coming 12/24 months opportunity continues.

6. Medical Workforce Race Equality Standard (MWRES)

In 2020 the Medical Workforce Race Equality Standard (MWRES) was introduced. The table below shows the profile of this staff group for ENHT from 2020 to 2023.

MWRES	2020			2021			2022			2023		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Consultants	46%	48%	7%	43%	47%	10%	43%	47%	11%	45%	50%	5%
Other Doctor Grades	20%	61%	18%	20%	60%	20%	14%	59%	27%	20%	73%	7%
Junior Doctors	34%	49%	18%	29%	42%	28%	29%	45%	26%	37%	56%	7%
TOTAL	**36%**	**51%**	**14%**	**32%**	**48%**	**20%**	**31%**	**49%**	**20%**	**37%**	**57%**	**6%**

The table demonstrates improvement in disclosure of equality data more generally, attributable to direct campaigns through networks, engagement and other forums as to the importance of enabling data evidence for decision making and increasing awareness of our organisational profile, overall a 14% improvement.

Over half of our medical workforce identify as Black, Asian or ethnic minority and ENHT engaging and understanding the lived experience can bring significant differences, an example is current work happening in maternity services with our junior doctors to hear how we can improve their placement experiences and learn back into the organisation, this has seen more engagement from consultants and midwives and is creating more psychologically safe working environments.

7. Areas of Focus and review of Actions 2023/24

Within the Healthy Culture team service, the EDI manager holds overall responsibility for the progress of inclusion for the Trust, supported through staff networks and the people partner team along with senior leadership and wider staff, the EDI manger objectives are contained at Appendix 3 for information for 2022/23. All work in this space, must include collaboration with the People Intelligence, Planning and Analytics team (PiP) to further look at WRES data at divisional level, produce our medical WRES and temporary workers (NHSP WRES) data submissions.
Equality, Diversity & Inclusion objectives historically have been set in view of metrics from various data such Workforce Disability Equality Standard (WDES), Workforce Race Equality Standard (WRES), Gender Pay Gap (GPG), themes from NHS Staff survey, qualitative input from staff Networks and we now move to a more holistic approach to deliver and embed changes and work needed to continue to improve our standing with inclusion in the trust and we will align future actions against the areas of the National EDI improvement action plan, show in the diagram below:

NHS equality, diversity, and inclusion improvement plan (page 7)
https://www.england.nhs.uk/wp-content/uploads/2023/06/B2044_NHS_EDI_Workforce_Plan.pdf

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

The table below shows the work undertaken over the last year and into the remainder of 2023/24 on our WRES.

WRES Action Plan Update and Plans for 2023/24

Objective	Actions	Metrics	Updates at July 2023	RAG rating
Equality, Diversity and Inclusion training To increase the view of BAME staff believing that trust provides equal opportunities for career progression or promotion	First steps towards - Leading inclusively with Cultural intelligence Plans to launch Reciprocal Mentoring for Inclusion in Sep 2022 and launch programme and create data base of mentors ICS and Inclusive Career Development Programme for BAME and Disabled members of staff Engaging on Regional Maternity/Neonatal Equity & Inclusion Ambassador scheme Diversity in Health and Care Partners programme Restorative Just Culture – engagement with Mersey Care NHS FT	**WRES 8 -** Percentage of BAME staff personally experienced discrimination at work from Manager/team leader/other colleagues **WRES 2** - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff **WRES 4** - Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff **WRES 7** – Percentage of BAME staff believing that trust provides equal opportunities for career progression or promotion **WRES 5 & 6** - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months / Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months	• Board and senior leader master class completed on cultural intelligence training • Reciprocal mentoring launches July 12, 2023 with 20 pairs – programme supported by an external facilitator and run for 1 year • Maternity programme to launch later in 2023 • Specific programmes from system and national shared widely informally and formally to increase take up • Head of ERAS and EDI and others trained in restorative just culture and wider sessions planned for early 2024	**Green** **Amber – Green** **Amber** **Amber – Green** **Green**
Inclusive recruitment Ensuring fairness in recruitment and selection	Positive action and practical support for candidates	**WRES 1** – Overall workforce % by Ethnicity	• Recruitment and Selection Training now includes greater focus on ED&I & values based recruitment, &	**Green**

process with attention given to employee life cycle. To deliver a representative workforce that reflects the community and delivers on model employer targets	Accountability and assurance framework in recruitment reviewed Secondment policy to be created and ratified, soon to be published, to support equity in opportunities within the Trust Onboarding and induction seamless and consistent for all Board representation and 8D increase in diversity	**WRES 2** - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff - Relative likelihood of White staff being appointed from shortlisting compared to BAME staff **WRES 7** – Percentage of BAME staff believing that Trust provides equal opportunities for career progression or promotion **WRES 9** - Percentage of voting members of the Board representation by ethnicity	includes unconscious bias, job descriptions, person specifications and adverts • Secondment Policy Launched April 2023 with review of all current secondments to complete by Sept 23 • Improved induction in place since Feb 2023 and review of e-learning underway throughout year • Vacancy arising at board provides opportunity	**Green** **Green – Amber (work to communicate required)** **Green** **Amber- Red**
Engage on Anti-Racism strategy Reducing uncivil behaviour and raising awareness of discrimination in all forms, and creating advocates and allies across the workforce Reducing incidents of discrimination and experience of bullying and harassment in the workplace measured through staff survey	Launching the See ME Fist campaign Delivery of civility saves lives programme and staff values charters for local teams Board representation and 8D increase in diversity	**WRES 5 & 6** - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months / Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months **WRES 5 & 6** - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months / Percentage of BAME staff experiencing harassment, bullying or abuse from staff in last 12 months **WRES 8** - Percentage of BAME staff personally experienced discrimination at work from	• Scheme launched in late 2022 early 2023 with many in brief articles and continues alongside celebration events • Values team talks and civility saves lives celebrated its first year and both are being embedded in the organisation • Opportunity to increase representation at board into 2023/24 due to vacancies and tenures expiring	**Green** **Green** **Amber**

		Manager/team leader/other colleagues		
Launch of two new documents, ENHT ED&I policy underpinned by our ENHT Equity & Inclusion strategy. The two documents will foster a co-production approach with staff side and staff networks and all relevant stakeholders to ensure its effectiveness, inclusivity, and sustainability. To increase morale and engagement – by creating a better feeling of inclusion and belonging people are happier, more productive and deliver better quality	Review of people policies on speaking up and encouraging staff to share their lived experiences through Equality, Diversity & Inclusion lens to include the lived experiences of disabled members of staff.	**WRES 3** - Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff **WRES 5 & 6 & &** - Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives, staff or managers in last 12 months **WRES 8** - Percentage of BAME staff personally experienced discrimination at work from Manager/team leader/other colleagues	EDI strategic Aims and operational priorities in place and survey to test level of importance closed July 7th this will inform content of a 3year Inclusion strategy for ENHT to launch by October 2023	

8. Priority Areas for 2024/25

Alongside the above actions to continue into 2024/25 and the priorities within the NHS equality, diversity and inclusion plan we will develop a single document to track, monitor and evaluate and bring together all the various inclusion actions and the diagram below captures the four pillars toward enabling us to deliver an inclusive place to work for all.

Equality Diversity & Inclusion Strategic Aims and *Operational Priorities*

NHS East and North Hertfordshire NHS Trust

Help build our equality, diversity and inclusion strategy

Our Equality, Diversity and Inclusion (EDI) team are looking for staff to complete a short survey which will be used to feed into Trust EDI strategy for 2023-2025. The team welcome feedback from all staff. Deadline to complete the survey is Friday 7 July. If you have any questions, please contact celina.mfuko@nhs.net Please use the QR code below to go to Survey Link

Appendices

Appendix 1: Making Anti-Racism a Reality

https://www.england.nhs.uk/east-of-england/nhs-east-of-england-equality-diversity-and-inclusion/antiracism-strategy/

Appendix 2: Representation by staff group

Healthcare Science

Row Labels	BAME	%	White	%	Not Known	%	Grand Total
Band 5	15	42%	13	36%	8	22%	36
Band 6	31	57%	20	37%	3	6%	54
Band 7	16	32%	27	54%	7	14%	50
Band 8A	2	9%	19	86%	1	5%	22
Band 8B	1	13%	7	88%		0%	8
Band 8C	2	29%	5	71%		0%	7
Band 8D		0%	2	100%		0%	2
Grand Total	67	37%	93	52%	19	11%	179

AHP

Row Labels	BAME	%	White	%	Not Known	%	Grand Total
Band 5	31	46%	22	33%	14	21%	67
Band 6	49	40%	61	50%	11	9%	121
Band 7	23	22%	73	70%	8	8%	104
Band 8A	5	20%	16	64%	4	16%	25
Band 8B		0%	3	100%		0%	3
Band 8C		0%	1	100%		0%	1
Band 8D		0%		0%	1	100%	1
Grand Total	108	34%	176	55%	38	12%	322

Scientific and Technical

Row Labels	BAME	%	White	%	Not Known	%	Grand Total
Band 5	37	51%	31	43%	4	6%	72
Band 6	29	47%	28	45%	5	8%	62
Band 7	17	46%	17	46%	3	8%	37
Band 8A	15	38%	21	54%	3	8%	39
Band 8B	5	50%	5	50%		0%	10
Band 8C	2	50%	2	50%		0%	4
Band 8D	2	67%	1	33%		0%	3
Band 9		0%	1	100%		0%	1
Grand Total	107	47%	106	46%	15	7%	228

Admin and Clerical

Row Labels	BAME	%	White	%	Not Known	%	Grand Total
Band 5	21	17%	100	81%	3	2%	124
Band 6	16	15%	89	82%	3	3%	108
Band 7	15	18%	63	74%	7	8%	85
Band 8A	19	30%	44	70%		0%	63
Band 8B	10	26%	27	69%	2	5%	39
Band 8C	2	6%	32	89%	2	6%	36
Band 8D	4	22%	14	78%		0%	18
Band 9	1	8%	11	92%		0%	12
Trust Pay		0%	14	100%		0%	14
Grand Total	88	18%	394	79%	17	3%	499

Nursing and Midwifery

Row Labels	BAME	%	White	%	Not Known	%	Grand Total
Band 5	588	69%	208	24%	53	6%	849
Band 6	281	40%	380	54%	43	6%	704
Band 7	121	27%	312	70%	14	3%	447
Band 8A	16	16%	80	81%	3	3%	99
Band 8B	1	6%	17	94%		0%	18
Band 8C	4	50%	4	50%		0%	8
Band 8D	1	33%	1	33%	1	33%	3
Band 9		0%	2	67%	1	33%	3
Trust Pay		0%	1	100%		0%	1
Grand Total	1012	47%	1005	47%	115	5%	2132

Appendix 3 – EDI manager Objectives 2022/2023

Key Objectives:

EDI Strategy. To complete and update the EDI strategy for the organisation. Utilising as wide a group as possible and showing clear areas in which the organisation will focus. To represent the Trust at regional and national level and engaged in best practice and research.

Cultural Intelligence. To complete the work on the programme at the senior level and to develop facilitators. To also produce an impact assessment and develop a longer term sustainable process. There may be a requirement for a business case for extra funding to train colleagues across the organisation.

EDS2 . To submit the report for this year and then to work with the three areas involved as they put into place the action agreed. To then start to prepare a wider programme in which more services are involved in the process through awareness and assessment but for our internal desire to improve as well as good preparation for future work.

Recruitment. To work with the resourcing team in developing a recruitment process that is in line with best practice. Reference to the materials and evidence in 'No More Tick Boxes' should be available in your work with the team. This may include recruitment training, audit etc and developing the Inclusion Ambassador project.

Induction / Onboarding - Training. To support the induction and onboarding process in order to ensure all new starters have a raised awareness of inclusion. Explore and pilot internal development programmes linked to the management and leadership development offered by Capability.

Gender Pay Gap. To complete both the reporting elements of the programme and devise a response to close the gaps identified.

Statutory Reporting / Annual Rhythm. To ensure that processes are in place to comply with the organisations statutory requirements. To create an accurate annual rhythm of expectations. Dates for awareness events, due reports, statutory requirements etc.

ICS / ICB / External. To represent the organisation in these domains and to ensure a connection to external practice and research which ensures ENHT is making informed decisions on its Inclusion agenda.

Health Inequalities. To work with a wide array of colleagues (especially from patient experience and business intelligence) in helping address this. Currently lead by the clinical and patient experience team with expert advice from the EDI lead.

Awareness / Networks. To play an active supportive part in the many awareness events throughout the year and to support, and encourage, participation from the entire workforce. To support the Engagement Lead in their role of leading and expanding the Networks in terms of membership, activity and impact.

Healthy Culture: Support the Healthy Culture approach utilising the models and tools developed to ensure commonality, rather than standardisation, as we move ENHT towards an environment where we live Include, Respect and Improve. (*a focus on the critical few). (related work based on 'No More Tick Boxes'.)

Meeting Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board		**Agenda Item**	10
Report title	Corporate Risk Register Review		**Meeting Date**	6 September 2023
Presenter	Margaret Okojie, Associate Director of Quality Governance/ Margaret Devaney, Director of Quality			
Author	Margaret Okojie, Associate Director of Quality Governance			
Responsible Director	Martin Armstrong- Deputy Chief Executive Officer & Director of Finance		**Approval Date**	
Purpose (*tick one box only)* [See note 8]	**To Note**	☒	**Approval**	☐
	Discussion	☐	**Decision**	☐

Report Summary:

East and North Hertfordshire NHS Trust risk register is presented for the board's information.

There are 14 open and validated risks on the corporate risk register aligned to the Trust's strategic objectives. Work is ongoing to effectively align operational risks held on the register to the Board Assurance Framework (BAF).

13 risks de-escalated from the corporate risk register. These include 9 risks that have been de-escalated for management at divisional level, 1 risk that has been agreed as a tolerated risk and 2 risks that have been merged following a review of data quality.

Impact: where significant implication(s) need highlighting
Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

N/A

Risk: *Please specify any links to the BAF or Risk Register*

N/A

Report previously considered by & date(s):

N/A

Recommendation	To note the updated Corporate Risk Register.

1. Background

1.1. The Audit and Risk Committee's responsibilities for risks are set out in its Terms of Reference.

1.2. The Trust has in place a recently refreshed Risk Management Strategy and Policy, which sets out the way the Trust manages its risks (strategic and operational) with clear guidance on how staff can assess, monitor, and manage risks. The policy will be reviewed every three years.

1.3. The Trust's Corporate Risk Register (CRR) holds a mix of operational and clinical risks that could potentially threaten and/or have a significant impact on the Trust's core business and the way it operates. Each division holds its own individual risk register which are managed by divisional triumvirate leads providing oversight of any risks that could threaten day to day operational activities.

As per the Trust's risk strategy and policy, risks rated 15 and above (high rated risks) and requires additional operational support can be brought to the risk management group as well as the Trust's Audit & Risk committee for consideration for inclusion onto the CRR. However, risks can also be removed from the CRR provided that sufficient mitigation measures/actions have been made and the risk rating score improved. The risk is then managed at divisional level.

The Trust's risk management group reviews the CRR and oversees its management.

1.4. The risk information provided within the CRR has been structured in such a way that each risk is 'owned' by executive directors and reviewed/revised/updated by staff colleagues within the indicated divisions under their leadership.

1.5. All identified risk leads/risk owners are responsible for reviewing and updating their individual risks. Every risk is reviewed in line with policy or when there is a significant change in circumstances.

2. Review of risk registers

2.1. The CRR was presented to the Audit and Risk committee in July 2023 following a review of all risks held by the divisions. An updated version was presented to the Trust Management Group in August 2023 for oversight.

2.2. Consequently, a broad level review was undertaken to align ENHT corporate risks to the Trust Board Assurance Framework (BAF).

2.3. A number of risks have been de-escalated from the CRR with agreement from the Trust Management Group as sufficient mitigations are in place to adequately manage these risks at a divisional level.

2.4. There is ongoing work to review all risks held within the register to ascertain current positions and risk mitigations which will support either the increase or decrease of risk scoring and whether risks have progressed sufficiently to support either the closure and/or de-escalation of said risks.

East and North Hertfordshire NHS Trust Corporate Risk Register

Risk no.	**Primary impact areas** Assets, Ease of Use, Finance, People, Pathways, Sustainability Quality	**Risk name** Risk that may affect ENHT	**Risk description** Impact on delivery of ENHT objectives, service delivery, reputation	**Date first entered on risk register**	**Initial likelihood** Score 1-5	**Initial Impact** Score 1-5	**Initial risk score** Likelihood x impact	**Tasks to mitigate risk** Controls/safeguards/precautions to date, noting any other factors that may influence the risk	**Revised likelihood** Score 1-5	**Revised impact** Score 1-5	**Current risk score** Likelihood x impact	**Additional actions required** What we plan to do within the next 12 months	**Executive Risk owner** ultimately responsible for risk
3027	Assets- Equipment Performance Finance Workforce Quality- Clinical Safety	Risk of Regulatory Non-compliance within Audiology Service **(Planned Care)**	Gaps in paediatric audiology pathways, aged environment/estate, high staff turnover/workforce gaps, limited digitalised processes, ineffective governance processes, limited supply of audiology testing equipment poses a risk of inaccurate record/ incomplete diagnosis. **(Materialised as an issue)**	06/05/2023	4	4	High risk 16	External oversight support from NHS England and the Integrated Care Board (ICB) Independent review commissioned to determine appropriate assurance processes. Workforce competency framework to achieve required skills & competency. Daily review meetings to identify patients at risk (oversight from senior team monthly). Established assurance process within service to provide oversight.	5	4	High risk 20 ⇧	Establish data triangulation from varying sources to address any ongoing concerns. Digitalisation of the process pathways. Review and address equipment/ environmental factors. Rectify workforce gaps.	Chief Nurse Chief Operating Officer Medical Director
0025	Finance	Risk of non-delivery/ failure to achieve agreed Financial Plan and Cost Improvement Programme (CIP) **(Corporate- Finance)**	Failure to achieve sufficient savings to deliver in year (2023/24) which could impact the Trust's cost saving plans.	01/03/2022	5	4	**High risk 20**	CIP monthly monitoring mechanism Monthly reporting to Finance Performance Committee Spotlight CIP reviews occur at a regular basis	5	4	**High risk 20** ⇔	Recruit into new post (CIP Accountant)	Deputy Chief Executive/ Director of Finance
0064	Workforce Performance- pathways Quality- Clinical Safety	Risk to staff and patients' wellbeing and quality of care delivered due to an increase in mental health patient admissions and attendances and reduced admission spaces/beds **(Unplanned Care)**	Increasing acuity of presentation in the number of patient attendance in the emergency department (including 16/17yr old's) with no corresponding numbers in skilled staff. This results in delayed and long waits.	11/10/2020	5	4	**High risk 20**	Mental health risk & challenging behavioral assessments carried out at triage & recorded electronically. Visible presence of Mental Health Matron to provide oversight & effective liaison with external partners (Hertfordshire Partnership NHS Foundation Trust) to expedite treatment plans, therapeutic input and bed placement.	5	4	**High risk 20** ⇔	No Further agreed actions	Chief Operating Officer Chief Nurse Medical Director
Risk no.	**Primary impact areas**	**Risk name** Risk that may affect	**Risk description** Impact on delivery of ENHT objectives,	**Date first entered on**	**Initial likelihood**	**Initial Impact**	**Initial risk score**	**Tasks to mitigate risk** Controls/safeguards/precautions	**Revised likelihood**	**Revised impact**	**Current risk score** Likelihood x impact	**Additional actions required** What we plan to do within the next	**Executive Risk owner**

	Assets, Ease of Use, Finance, People, Pathways, Sustainability Quality	ENHT	service delivery, reputation	**risk register**	Score 1-5	Score 1-5	Likelihood x impact	to date, noting any other factors that may influence the risk	Score 1-5	Score 1-5		12 months	ultimately responsible for risk
1923	Performance- patient flow Workforce Assets- Estates & environment	Risks to patient safety and staff well-being due to overcrowding in the Emergency Department (ED) and lack of assessment space including waiting room care **(Unplanned Care)**	Overcrowding/ increased patient numbers in ED leading to longer wait times, insufficient trolley spaces, inappropriate wait areas (ambulance, ED corridor, chairs). Impact on staff well-being noted as ratio of patient to staff stretched during peak times/high OPEL (Operational Pressures Escalation Levels) status.	15/6/2012	3	5	**High risk 15**	Escalation at daily site Meetings Escalation protocol & Reaction during periods of overcrowding established. Overcrowding risk assessments in place Increased Consultant presence and rapid assessment to improve patient flow. Navigation Nurse Manager visible in main waiting area. Treatment Nurse allocated to waiting room to ensure timely treatment interventions.	4	5	**High risk 20** ⇧	Scope Electronic Referrals systems- Bed management and tracking system- What is feasible Implementation of 6-point plan – UCE development plan Explore Service Level Agreements (SLA/E) in line with safety hurdles Review internal professional standards to ensure effective communication sharing with specialty team	Chief Operating Officer Medical director Chief Nurse
3028	Pathways Assets- Estates Quality- Clinical Safety	Risk of delay in transfer of deteriorating patients with co-morbidities as a result of inadequate onsite acute facilities to support patient care. [this relates to MVCC] **(Cancer Services)**	Deteriorating patients and patients with co-morbidities must be transferred out to a local District General Hospital) DGH as Mount Vernon Cancer Centre) (MVCC) do not have onsite acute facilities to support the care of these patients resulting in some patient non-attendance for cancer treatments. This has created further fragmentation of care resulting in suboptimal care and poor patient experience.	09/05/2023	4	4	**High Risk 16**	External peer review of the 30-day mortality post Systemic Anti-Cancer Therapy for ovarian patients. Bolster AOS (Acute Oncology Service) outreach support to DGHs to minimise fragmentation. Tracking ongoing care of cancer patients in local DGH's: Recruit to AOS role and re-introduce AOS meetings with local DGH (District General Hospital) teams.	5	4	**High risk 20** ⇧	Embed learning from incidents and complaints relating to cancer patients. Develop direct patient pathways with Watford to introduce an AOS in ED at The Lister. *NB Long term solution – transition to acute hospital site.*	Deputy CEO Medical Director Chief Nurse

Risk no.	**Primary impact areas** Assets, Ease of Use, Finance, People, Pathways, Sustainability Quality	**Risk name** Risk that may affect ENHT	**Risk description** Impact on delivery of ENHT objectives, service delivery, reputation	**Date first entered on risk register**	**Initial likelihood** Score 1-5	**Initial Impact** Score 1-5	**Initial risk score** Likelihood x impact	**Tasks to mitigate risk** Controls/safeguards/precautions to date, noting any other factors that may influence the risk	**Revised likelihood** Score 1-5	**Revised impact** Score 1-5	**Current risk score** Likelihood x impact	**Additional actions required** What we plan to do within the next 12 months	**Executive Risk owner** ultimately responsible for risk
0051	Quality People Sustainability	Risk of irreversible sight loss due to delay in the ophthalmology service recovery which has been exacerbated post COVID. **(Planned Care)**	Multifactorial risk factors include high risk patient cohorts, high volume outpatients' clinics & short notice interventions Service review outlines areas of possible risk mitigation in recruitment & retention, demand & capacity, equipment purchase and staff resource.	01/10/2020	4	4	**High Risk 16**	Waiting List Initiative clinics in place to assist with demand and backlog of patients Job plans reorganised into sub-specialty job plans which are overseen by specialty Consultants Clinical review of patient records & patient stratification. Review of outpatient space and patient flow	5	4	**High Risk 20** 	Review of virtual clinics in the absence of Electronic Patient Records (EPR) system Procurement of EPR system Implementation of Community Diagnostics Hub (discussions with Integrated Care Board (ICB) commenced) Recruit to additional Consultant post Contract negotiation with the ICB to address system wide required funding.	Chief Nurse Chief Operating Officer Medical Director
0034	Assets- Service Delivery Ease of Use Finance	Risk of potential System outage or Data loss as a result of systems not being adequately Patched or protected from Cyber-attacks. **(Corporate- Digital)**	This could be due to Legacy clinical software not compatible with supported servers or through Networks or servers being installed outside of Digital governance or change control. Existing 18 x Windows Server 2008 Winpath servers cannot be upgraded, as the current pathology Laboratory Information system (Winpath LIM) is Legacy and only works on unsupported Microsoft server/client. Risks of compromise found on IT services operated by MVCC	28/07/2022	5	4	**High Risk 20**	Move to HWE outsource Pathology would mitigate this risk but the potential delay in contracting needs and recent Cyber-attacks mean an imminent review is required. Following the MVCC Cyber-attack work is underway to secure current services and identify other services in the Trust that may be operated outside of Digital and at risk of compromise	5	4	**High Risk 20** 	Part of the Trust dependency programme to replace the Pathology system with the Winpath Enterprise. No further agreed actions	Chief Information Officer
0061	Assets- Equipment Quality Finance	Risk of sight loss due to delay of identification of sight threatening diabetic retinopathy as a result of ageing screening cameras.	Key retinal screening cameras near end of lifespan (2023) which are required for the effective screening of 25K patients per year and account for £1M/year income for the ophthalmology service resulting in inability to meet national KPI	19/05/2022	5	4	**High Risk 20**	Cameras supported with annual Planned Preventive Maintenance (PPM) contract. Incidents being monitored and addressed, i.e., breakdowns/failure of cameras and patient cancellations.	4	4	**High Risk 16** 	Screening service out to tender	Deputy CEO
0066	Assets- Estates & Facilities	Risk of microbial colonisation due to inadequate hot water temperatures as a result of equipment failure & temperatures falling below required levels **(Corporate- Estates)**	The existing hot water system is unable to maintain system temperatures. Water quality and temperatures in Strathmore ward and Maternity block are difficult to maintain and adverse sample results indicate that the Trust is unable to maintain water quality to an acceptable standard on an ongoing basis	05/08/2022	4	4	**High Risk 16**	Procedures for flushing, sampling, testing and remedial actions in the event of any non-conformities, in place. Backlog maintenance programme 2023/4 underway (water system replacement and remedial works)	4	4	**High Risk 16** 	Installation of equipment to facilitate hourly monitoring. Completion of remedial works.	Director of Estates

Risk no.	**Primary impact areas** Assets, Ease of Use, Finance, People, Pathways, Sustainability Quality	**Risk name** Risk that may affect ENHT	**Risk description** Impact on delivery of ENHT objectives, service delivery, reputation	**Date first entered on risk register**	**Initial likelihood** Score 1-5	**Initial Impact** Score 1-5	**Initial risk score** Likelihood x impact	**Tasks to mitigate risk** Controls/safeguards/precautions to date, noting any other factors that may influence the risk	**Revised likelihood** Score 1-5	**Revised impact** Score 1-5	**Current risk score** Likelihood x impact	**Additional actions required** What we plan to do within the next 12 months	**Executive Risk owner** ultimately responsible for risk
0036	Pathways-Processes Quality-Clinical Safety	Risk of delay in patient treatment within plastics as a result of same day clinical appointment cancellation due to inadequate clinical space for paediatric plastics **(Corporate- Estates)**	Following the relocation of plastics from Strathmore to Bramble ward clinic capacity has reduced from 4 to 2 rooms with late starts and reduced clinic schedules. As a result of limited space, the risk to overcrowding is significant which impacts on extended patient wait times.	02/05/2022	5	3	**High Risk 15**	Incidents and complaints arising from change in clinic setting are monitored	5	3	**High Risk 15** ⇔	Establish options for PDC working with the Space Utilisation Group	Chief Operating Officer Director of Estates
3026	Assets-Estates & Facilities Quality-Clinical Safety	Risk of potential delays to patient care as a result of unavailability of safe medical equipment/ devices which may impact timely patient care pathways **(Corporate- Estates & Facilities)**	The Trust has a limited supply of portable medical equipment and associated governance monitoring has not always been effective. This is due to: 1) Planned Preventative Maintenance (PPM) processes not consistently observed due to regular clinical use and/or unaccounted for. 2) Medical equipment not fit for purpose/reliable due to end of maintenance support 3) Maintained and safety check dates not always checked by the clinical user before use.	06/05/2023	4	4	**High Risk 16**	PPM schedule in place. Staggered renewal of non-**Electro-**Bio Medical Engineering (EBME) assets: Monthly compliance report issued to clinical service leads Scheduled servicing programme shared with clinical leads to ensure availability of equipment PAT testing and electrical safety testing programmes Revision and update of relevant policies Review of associated contracts and servicing schedules	4	4	**High Risk 16** ⇔	Equipment amnesty Complete survey of “missing” equipment; this follows an audit carried out by external company. Implementation of a new equipment management database Radio frequency interaction tagging (RFID) project in collaboration with digital team	Director of Estates
0044	Quality-Clinical Safety	Risk of harm to patients due to delays in delivery of emergency surgery caused by a lack of Emergency General Surgery list capacity **(Planned Care)**	The current emergency list in theatre 7 is shared with all specialties including Emergency Laparotomy patients. Not having a dedicated emergency list for the other general surgical patients causes delay in the care of abscess, appendicitis and gallstone patients leading to poor outcomes/increasing length of stay or admission.	25/05/2021	5	3	**High Risk 15**	New SOP to improve utilisation of the emergency theatre is being implemented. Surgeons that have a case for the emergency list must be at the 08:30 briefing to discuss clinical urgency and agree list order. Review use of new procedure room to relieve pressure in the department and provide capacity for emergency cases.	5	3	**High Risk 15** ⇔	Actions in progress to achieve a ‘Surgical Assessment Unit’ co-located with AMU. Staffing roster agreed and clinical pathway for admission. Bed space allocation now allocated. Aim go live End of Sept 2023.	Chief Operating Officer

Risk no.	**Primary impact areas** Assets, Ease of Use, Finance, People, Pathways, Sustainability Quality	**Risk name** Risk that may affect ENHT	**Risk description** Impact on delivery of ENHT objectives, service delivery, reputation	**Date first entered on risk register**	**Initial likelihood** Score 1-5	**Initial Impact** Score 1-5	**Initial risk score** Likelihood x impact	**Tasks to mitigate risk** Controls/safeguards/precautions to date, noting any other factors that may influence the risk	**Revised likelihood** Score 1-5	**Revised impact** Score 1-5	**Current risk score** Likelihood x impact	**Additional actions required** What we plan to do within the next 12 months	**Executive Risk owner** ultimately responsible for risk
1127	People-workforce Quality-Clinical Safety	There is a risk to babies care and treatment as a result of insufficient numbers of Consultant and Middle Grade Neonatologists which would impact compliance with BAPM (British Association of Perinatal Medicine standards) **(Women & Children)**	There are insufficient Consultant and middle grade neonatologists to support activity on the Consultant Led Unit (CLU) in the care of babies requiring resuscitation/support following birth and these do not meet BAPM standards as required for MIS and stipulated in the final Ockendon report. We currently have 5 consultant neonatologists. BAPM advises 7. At nighttime the neonatal registrar also has responsibility for the paediatric ward – this contravenes BAPM standards.	02/08/2022	5	3	**High Risk 15**	Additional on-call shifts to cover staff shortages Consultants undertaking additional 1:5 on- calls. Monitoring of reported incidents. Paediatric doctors used to support the neonatal service Weekly monitoring of rotas and workload to ensure shift cover and minimise staff burnout: locum/agency staff utilised, where required	5	3	**High Risk 15** ⟺	Funded 1 additional consultant neonatologist post – this is out to advert. Applied for regional funding for post 7 and 2 additional middle grade posts.	Medical Director
1273	People-Workforce Quality-Clinical Safety	Delays in Reporting of diagnostic scans in the Paul Strickland Scanner Centre (PSSC) leading to a greater risk of delay in treatment to cancer patients. **(Cancer Services)**	Delays in CT reporting times of up to 3 weeks due to staff sickness and vacancies within PSCC at Mount Vernon Cancer Centre (MVCC). Impact seen in delays to treatment and poor patient outcomes. Patient outcomes.	12/12/2022	4	4	**High Risk 12**	Clinical teams informed of scans due each week. Clinic lists sent in advance to PSSC to enable prioritising of reporting. Scan requests to contain clinic information where possible to help with prioritising reporting. Printed reports uploaded to shared drive.	4	4	**High Risk 16** ⟺	Recruitment to PSSC team. PACS licenses to be issued to clinicians The link to support remote PSSC Picture Archiving & Communication System (PACS) access in MVCC has not been achieved.	Chief People Officer

Prepared by: Associate Director of Quality Governance

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	11
Report title	Annual Freedom to Speak Up Report (2022/ 23)			**Meeting Date**	6 September 2023
Presenter	Freedom to Speak Up Guardian				
Author	Freedom to Speak Up Guardian				
Responsible Director	Chief Nurse			**Approval Date**	
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

The purpose of the report is to give the board the opportunity to hear directly from the Freedom to Speak Up Guardian and to provide an overview of the progress and development of the Speak Up service including:

- Continued commitment to support 'Speaking up' and promote a just, restorative and learning culture that proactively encourages conversations
- Continued focus on local resolution, responsiveness, and organisational learning from Freedom to Speak Up (FTSU) concerns raised
- Thematic analysis and learning for the last financial year (2022/23) from FTSU concerns raised including:

  62% of concerns related to *worker safety or wellbeing* (41% cases related to breakdown of relationship between line manager and employee, 13% related to failure to follow systems and processes, 5% related to health and safety including staff experiencing aggression and violence from service users and 3% related to inequality and discrimination)

  23% concerns related to *inappropriate attitudes or behaviors*, primarily incivility

  8% concerns related to *patient safety and quality*

  7% concerns related to *Bullying and Harassment*

- Ethnicity breakdown of staff Speaking Up is 55% black, brown and minority ethnic group compared with 43% white British and other white ethnicity group.

- Seek Board approval to develop leadership programme for all line managers to help them gain people management skills that are in line with our Trust values. This programme will have the added benefit of helping our people to thrive and grow, improve retention and staff experience.

- Endorse the Trust Speak Up Policy (appendix 1) that has been approved via the Trust policy governance process.

Impact: where significant implication(s) need highlighting *Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal* *Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability* *CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources*
This work directly impacts: • On our delivery of the People Promise, enabling improved staff survey and satisfaction at work results. • On patient safety, standards of care and service user experience • On work culture including lived values • Indirectly reduced levels of complaints and legal cases raised by staff against the Trust.
Risk: *Please specify any links to the BAF or Risk Register*
Poor speaking up arrangements and lack of psychological safety is likely to increase risk of patient safety incidents, drop in accepted standards set within policies and guidelines. This may have negative impact on service user experience Poor staff experience could increase negative staff survey results, increase turnover, sickness absence rates and on-going recruitment costs.
Report previously considered by & date(s):
[See note 12]

Recommendation	The Board is asked to note , discuss and support actions

To be trusted to provide consistently outstanding care and exemplary service

Email completed coversheet and related paper to: boardcommittees.enh-tr@nhs.net

Introduction:

The National Guardian's Office (NGO) and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis QC's report which investigated failures in care at the Mid Staffordshire NHS Foundation Trust. These recommendations were made as Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a result. The NGO leads, trains and supports Speaking Up strategy within the NHS including monitoring the number and themes of concerns raised by NHS staff.

Background:

This report reflects the first year of increased Freedom to Speak Up (FTSU) service (1.0WTE compared with 0.5WTE previous post holder) as this is our Trust FTSU Guardian, Sylvia Gomes' only role. The improved capacity and structure has enabled 'Speaking Up' support to be accessible any 5 days per week including weekends. The increased investment in supporting our colleagues to Speak Up demonstrates a positive shift within our Trust to building an open, transparent and psychologically safe work environment.

Our Chief Nurse, Theresa Murphy, and Non-Executive Director (NED) Val Moore are responsible for providing oversight and guidance to the FTSU service. Governance is provided by the People Committee, offering assurance in relation to process and clear connectivity to the People Priorities and People Promise.

1.0 Operational function of the service includes:

1.1 FTSU Guardian's role in supporting and resolving issues:

- Being available and responsive to staff is vital to FTSU Service. All staff receive a response within 48 hours of contacting the FTSU Guardian. Staff are always offered the choice of where/ how and when they wish to meet the guardian which can be on site or off site/ in person/ on teams or via phone
- As the aim is to make Speaking Up business as usual, staff are always encouraged to speak to their immediate or second tier line manager in the first instance unless there are sound reasons for not doing so. If staff member feels unable to do this on their own, then, with consent from both parties, the FTSU Guardian has helped facilitate a meeting with their manager, or the individual involved.
- Staff are advised at the start of the discussion that should their concern have elements of patient, staff safety or safeguarding, the concern must be escalated immediately.
- Support is provided by listening, coaching and encouraging staff to raise their concerns directly with their manager. Sometimes listening to understand is all that was required.
- FTSU Guardian has helped identify range of options when staff member has raised concerns. Often staff are unable to see the full picture when they are absorbed in the issue. By exploring options, staff are sometimes able to see a solution to their concerns. This has been reflected in the publication of the Speak Up policy 2023.
- FTSU Guardian has played a crucial role in de-escalating issues by supporting local resolution and linking in with Trust OD team to enable development at a practical level with individuals, teams, and services.

1.2 Raising awareness of Freedom to Speak Up

Speaking Up helps improve patient safety, quality of care and has a positive impact on service user and staff experience.

Therefore the FTSU Guardian has ensured that:

1. Staff members who have approached FTSU Gaurdian with concerns are supported in speaking up.
2. Any barriers to speaking up are addressed promptly
3. Helped influence a positive culture of speaking
4. Issues raised are used as opportunities for learning and improvement.
5. Any clinical or immediate safety concerns are escalated appropriately, while supporting staff who have spoken up. Where necessary ensuring incident reporting episodes completed.

1.2.1 Supporting Maternity and Neo-natal services

Maternity services have deployed routine FTSU drop-in sessions, lasting for 60 to 90 minutes. These sessions are cascaded daily, then transition to weekly and will also include neonatal services. The sessions are inclusive of late evenings (for night shift) and weekends.
Themes, trends and learning form these sessions shall follow the agreed governance reporting structure for assurance across actions within the Quality and Safety Committee.

1.3 Speak Up Champions:

The last financial year, 16 Speak Up Champions were recruited and trained, bringing the total number of Speak Up Champions to 28. Recruitment has been inclusive, reflecting our diverse workforce and representing variety of staff groups, grades, and ethnicity to include all professional streams (Nurses, Midwives, Doctors, Therapists, Operation Department Practitioners, Radiographers, Health Care Support Workers, Administration and Clerical Staff).

Staff Group	**Numbers**
Additional Professional Scientific & Technical	1
Additional Clinical Services	4
Administrative & Clerical	8
Allied Health Professionals	3
Medical & Dental	3
Nursing & Midwifery Registered	9
Total	**28**

Speak Up Champions help influence the Speak Up culture within their departments, signpost colleagues who wish to speak up and help address barriers to Speaking Up. The Champions meet monthly to network, share learning and generate awareness to issues experienced by our People

1.4 Freedom to Speak Up Month:

October 2022 was promoted as Speak Up month and used a variety of avenues to share information:

- Each week in October was promoted with a theme in line with NGO (Speak Up for Safety, Speak Up for Civility, Speak Up for Inclusivity and Speak Up for Everyone)
- Anonymised learning and feedback from Speak Up case was shared in Trust newsletter
- Trust Civility video was promoted within clinical departments to generate 'Civility Saves Lives' awareness.
- FTSU Guardian shared anonymised feedback from Trust staff member detailing senior managers behaviour at meeting as part of Trust Board Development to enable reflection and learning.
- FTSU Guardian facilitated reflective learning session at leadership forum by sharing anonymised Speak Up case. This session generated discussion on how we can learn as an organisation and leaders made commitments to creating a psychologically safe environment within their team
- FTSU Guardian also delivered talks and presentations on Speaking Up; Psychological Safety, and influencing just, restorative and learning culture at Leadership Forum, Quality Huddle, departmental governance sessions, divisional meetings, rolling half day audit meetings and team meetings
- FTSU Guardian attended senior managers meetings, staff network groups, People Committee, Trust Partnership, Quality and Safety meetings to work collaboratively with the wider organisation to create and promote a Speaking Up culture
- Training delivered to 8 Speak Up Champions including 1 doctor.
- Speak Up Champions pledges poster was displayed in staff experience hub to promote the importance of Speaking Up.
- FTSU Guardian visited departments Trust wide and cross site to introduce 'Speaking Up' and build connections with staff and managers
- The promotion of Speak Up month reflected a rise in staff raising concerns

1.5 Regional and National Networking:

FTSU Guardian has networked outside the Trust including attending regional meetings and has set up regular meetings with FTSU Guardian at neighbouring Trusts to share learning. FTSU Guardian attended annual Speak Up conference hosted by the NGO

The next section of this report provides the statistical data of matters raised to the FTSU Guardian, assessment of the issues and themes, areas where issues are being raised, as well as outlining actions taken or underway.

2.0 Annual review of issues 2022/23

2.1 Assessment of Issues

2021/2022 – 2022/2023 Comparison

Year	2021/2022	2022/2023	Comments
No. of Speak Up Cases	90	191	Increase in Speak Up cases reflects increase in FTSU service

Number of concerns raised this financial year (2022/23) by quarter:

	Q1	Q2	Q3	Q4	Total
Total Cases	40	31	81	39	191

Cases Closed	40	31	80	36	187
Cases Open	0	0	1	3	4

Open cases are actively monitored, and regular contact is maintained by the FTSU Guardian with the staff member.

2.2 Themes:

This is in line with the NGO's recommended themes. The breakdown is as follows:

Themes	Number	Percentage
1. Worker Safety or Wellbeing	119	62%
2. Patient Safety/ Quality	15	8%
3. Bullying and Harassment	14	7%
4. Inappropriate attitudes or behaviours	43	23%
5. Disadvantageous or demeaning treatment because of Speaking Up	0	0
Total	191	100%

2.3 Who is speaking up?

Concerns raised by staff groups (as defined by NGO)

Staff Group	Number of Concerns Raised	Percentage
Additional Professional Scientific & Technical	9	5%
Additional Clinical Services	39	20%
Administrative & Clerical	39	20%
Allied Health Professionals	7	4.5%
Estates & Ancillary	0	0%
Healthcare Scientists	0	0%
Medical & Dental	12	6%
Nursing & Midwifery Registered	84	44%
Students	0	0%
Unknown (anonymous)	1	0.5%
Total	191	100%

2.4 Who is speaking up by Ethnicity?

Ethnicity	Number	Percentage
Asian	45	23.5%
Black	42	22.5%
Mixed (Asian & White British)	6	3%
Mixed (Black & White British)	12	6%
Mixed (other)	3	1.5%
White British	70	37%
White (other)	12	6%
Unknown	1	0.5%
Total	191	100%

2.5 Themes in more detail:

1. **Worker Safety or Wellbeing:** This relates to cases where there is a risk of adverse impact on worker safety or wellbeing including work related stress. Majority of cases (41%) relate to breakdown in relationship between line manager and employee. Both managers and employees need to be supported with resolving the issue and moving forward. In some circumstances, early mediation may have stopped issues from escalating to a formal complaint process. 13% cases relate to failures in following due process when dealing with either employment or performance issues and some cases involved agenda for change re-banding process. 5% cases relate to health and safety including staff experiencing aggression and violence from service users and 3% relate to inequality and discrimination

   Action: Managers need support to manage performance and attendance issues to ensure that any action taken is just and restorative.

   Managers need coaching/ training to gain people management skills.

   Staff in patient/ service user facing areas to complete Breakaway training

   To continue Cultural Intelligence work that has started within the organisation including training, reverse mentoring, inclusion ambassadors and staff network streams.

2. **Behavioural / Inappropriate attitudes (Incivility):** 23% concerns raised related to interactions that lacked civility and respect and dignity. This contributed to poor psychological safety within teams. All grades of staff including managers were impacted by this. Majority of staff who experienced incivility reported that it had a negative impact on their well-being and their ability to promote patient safety when working as part of the multidisciplinary team to deliver safe care. Some staff reported they felt anxious and dreaded coming to work.

   Actions:

   - Healthy Teams action plan in progress to set the cultural tone in line with Trust values and facilitate departmental values and behaviour charter.

- Provision of timely supportive feedback and coaching to staff involved to help them develop communication style that reflects our Trust values.

3. Patient safety concerns:

Patient safety concerns primarily related increased demand and limited resources to meet this demand.

- Staffing shortfall including poor skill mix
- Insufficient equipment
- Deviation from agreed standards

Action:

- Managers need coaching/ training to gain skills to embed psychological safety within their team.
- Insufficient equipment and deviation from standards must be reported via incident reporting system Enhance to initiate due process, review and learning

4. Bullying and Harassment:

14 members of staff raised concerns about bullying and harassment. 8 staff members decided to leave the organisation as they did not trust the investigation process. 6 staff members have raised concerns with Employee Relations Advisory Service (ERAS) via Trust grievance process.

Action: Managers need pastoral support when allegations of bullying and harassment are made against them.

Managers need coaching/ training to gain people management skills.

Early interventions including mediation and facilitated conversations can help resolve issues and heal workplace relationships. Therefore, it is essential that managers seek advice promptly when allegations of bullying/ harassment are made.

3.0 Concerns raised via other avenues:

3.1 Speak In Confidence: Staff within our organisation can raise concerns anonymously via the Work in Confidence (WIC) platform. To use this, staff initially need to register and then start a conversation anonymously with a named manager who is listed as conversation recipient. The manager emails their response to WIC and the staff member is able to see that as a message on the platform and can continue the dialogue to resolve the issue they have raised.

In the financial year 2022 /23 there were 4 concerns raised via WIC:

- Employment Terms and Conditions
- Bullying & Harassment
- Staff Support measures
- Leadership and Management

3.2 Anonymous concerns raised with CQC:

4 concerns were raised anonymously in the year 2022/23

2021/2022 – 2022/2023 Comparison

Year	April 2021 – March 2022	April 2022 – March 2023
Number of anonymous concerns	4	4

In October 2022, concerns were raised anonymously with CQC relating to staffing levels in Ward 8B. These concerns involved staffing rotas, in particular the use of bank staff on the ward at weekends (as opposed to permanent staff). The concern was also linked to a clinical incident where a patient was not put back onto oxygen therapy following nebulisation and subsequently passed away.

In the same month, CQC raised concerns with our Trust following staff focus group and requested assurance on the following:

- ITU staffing plan and mitigation
- General staffing plan for planned and unplanned divisions
- Trust response to amber blood alert including actions and underpinning governance

In November 2022, CQC received anonymous letter raising concerns relating to working conditions within ED at Lister Hospital. These related to staffing levels, overcrowding of waiting area, incidents of service users verbally and physically abusing staff.

In January 2023 CQC received anonymous letter raising concerns relating to management of urgent 2 week booking of endoscopy appointments and the increasing amount of paper referrals that required adding to the online system.

3.3 Ask Adam email inbox: Staff within our organisation can contact our CEO directly to raise concerns by emailing ask.adam@nhs.net.

The concerns raised directly with our CEO fall under the following themes:

- Parking – specifically at Lister Hospital (availability, disabled parking, access to parking, people parking in wrong areas)
- Staff feeling valued – long-service badges, forgotten during celebration week, importance of staff-only areas such as the coffee lounge
- Smoking at the Trust
- Breaching pension allowance
- Missing pension details
- Cleanliness and maintenance of areas and buildings

These issues were addressed on a case-by-case basis

4.0 Achievements:

- New Speak Up policy in line with recommendations made by NHS England and NGO, approved via Trust policy governance process
- Rise in Speak Up cases from our people, reflecting our diverse workforce and representing variety of staff groups, grades and ethnicity
- Increase in local resolution/ facilitated conversation/ mediation
- 77% of our workforce have completed Speak Up training on ENH academy
- Speaking Up is part of corporate induction and included in a variety of meetings including Leadership Forum, Quality Huddle, consultant induction, medical trainee induction, local negotiation committee and junior doctor forum
- Sustained increase in cross-site visibility of FTSU Guardian including site specific all staff team briefings and departmental meetings
- FTSU workshop delivered at Mount Vernon Cancer Centre and Lister hospital. Plan in place to deliver this at Queen Elizabeth II and Hertford County Hospitals.

5.0 Learning and Improvement:

1. Fear continues to be a barrier to Speaking Up. The need to develop healthy teams and embed psychological safety within teams continues. There are several positive streams of work in play within our organisation including Healthy Teams, Values and Behaviours and What Matters to You. We need to connect these initiatives to ensure effective delivery on Trust strategy. In addition to this, training is available to help staff to gain skills to Speak Up and for managers to Listen Up. It is essential that all staff access this training to promote speaking up within the organisation.
2. Support for managers: Many colleagues who have been promoted internally to management position are not given a period of induction or additional training to fulfil their role. This has not given newly promoted managers the opportunity to gain skills needed to manage their team members. Bite sized inhouse leadership programme will help managers gain skills and build supportive network with other managers within the organisation
3. To work towards our goal of making Speaking Up business as usual, managers need to include FTSU within their agenda for team meetings biannually and invite either FTSU Guardian or Speak Champion to join their meeting
4. As civility saves lives, it is essential that the Trust video on civility is shared widely across our Trust with teams and shift our organisational culture to a place where our values of Include, Respect and Improve are lived
5. The FTSU Guardian will continue to contribute to the NGO mission. Part of this work is to submit and support requirements from the NGO. These include quarterly submissions, regional meetings and other surveys.

6.0 2023/24 Recommendations:

1. All staff complete Speak-Up training available via ENH Academy
2. All managers complete Listen Up training in addition to above
3. All teams to work in partnership with Trust OD team to draw up a team charter including behaviours that reflect our values

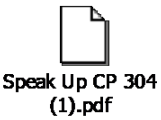
4. FTSU Guardian continues work stream that has started to grow staff confidence in 'Speaking Up'
5. FTSU Guardian continues to link in with OD to enable development at a practical level within individuals, teams and services
6. Initiate a speaking up oversight panel, with key stakeholders meeting regularly to support immediate actions in response to themes reported.
7. Co-design and publish a meaningful ENHT Speaking up strategy, with agreed milestones

The committee is asked to:

- Consider and comment on the themes, trends and issues arising from this report
- Support the drive for cultural change, including living our new values (Include, Respect and Improve) by scrutinising the organisations approach to leadership development and people management and seek assurance there are clear plans and resources in place to support this.

Appendix 1

Speak Up Policy



Speak Up CP 304 (1).pdf

DOC ID: CP 304

East and North Hertfordshire NHS Trust

Speaking Up Policy

About this document	
Document ID	CP 304 **Version:** 001
Full review due before	[ADMIN ONLY]
Document type	Policy
Usage & applicability	For use Trust wide by all roles at all sites

Summary

Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up without fear and their voices will be heard, and result in meaningful actions.

This policy ensures that:

- All our workers (permanent employees, agency staff, students, contractors and volunteers) have a voice that counts
- We all feel safe and confident to speak up.
- We take the time to really listen to understand the hopes and fears that lie behind the words.
- Build a culture and behaviours that is responsive to feedback from workers
- Ensure in line with Trust values, we focus on learning, to continuously improve quality of care and the experience of staff, patients and service users alike

What you need to know about this version

VERSION TYPE: **New document – full consultation with endorsements**

Document control info and governance record in "PART 4 - Document information"
Disclaimer: This document is uncontrolled when printed. See intranet for latest version.

Contents

1. Scope

Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.

This policy is for all workers (permanent employees, agency staff, students, contractors and volunteers) and we want to hear all our workers' concerns.

We ask all our workers to complete the online training Speaking Up. The online module Listen Up is specifically for managers to complete and the module Follow Up is for senior leaders to complete.

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

2. Purpose

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to have a policy on Speaking Up. As a minimum standard this policy intends to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

3. Duties

The Freedom to Speak Up Guardian with support from the Trust Executive team is accountable for the Speaking Up policy and the FTSU strategy.

All team leaders and line managers are responsible for implementing this policy.

4. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Absence Policy	HR 009	☒ENHT | ☐Affiliated network | ☐National/ regional
Change Management Procedure	HR 32	☒ENHT | ☐Affiliated network | ☐National/ regional
Dealing with Relationships at work	HR 67	☒ENHT | ☐Affiliated network | ☐National/ regional
Dignity and Respect at Work Policy	HR 15	☒ENHT | ☐Affiliated network | ☐National/ regional
Disciplinary Policy	HR 10	☒ENHT | ☐Affiliated network | ☐National/ regional
Employee Performance Improvement	HR 31	☒ENHT | ☐Affiliated network | ☐National/ regional
Investigations Policy	HR 52	☒ENHT | ☐Affiliated network | ☐National/ regional
Recruitment and Selection Policy	HR 17	☒ENHT | ☐Affiliated network | ☐National/ regional
Work Life Balance Procedures	HR 53	☒ENHT | ☐Affiliated network | ☐National/ regional
Management of incidents and serious incidents requiring investigation & learning policy	CSEC 49	☒ENHT | ☐Affiliated network | ☐National/ regional

5. Monitoring compliance

This document will be reviewed in **3 years** or earlier if any evidence or change in practice comes to light requiring an update to the document. Any further activity to monitor to the use and compliance of the document at the Trust is documented below.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Relevance in line with national guidance	Annually	Freedom to Speak Up Guardian	Chief Nurse	People Committee will be made aware of any deficiencies/ gaps.

5.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, applies to all, regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

This evidence is in the form of an equality impact assessment (only if initial screening form below prompts a full EIA) – a process which should be embedded within the early stages of

planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:		**Impact Yes/No**	**Comments**
1	Age (younger people & children & older people)	No	
2	Gender (men & women)	No	
3	Race (include gypsies and travellers)	No	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	No	
5	Religion/Belief	No	
6	Sexual Orientation (Gay, Lesbian, Bisexual)	No	
7	Gender Re-assignment	No	
8	Marriage & Civil Partnership	No	
9	Pregnancy & Maternity	No	
10	Is there any evidence that some groups maybe affected differently?	No	
11	Could this document have an impact on other groups not covered by a protected characteristic? (e.g.: low wage earners or carers)	No	
If '**NO IMPACT'** is identified for any of the above protected characteristics, then no further action is required.			
If '**YES IMPACT**' is identified a full impact assessment should be carried out in compliance with HR028 Equality & Human Rights Policy and linked to this document			
Any other comments: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.			
EIA screening form completed by: Sylvia Gomes, Freedom to Speak Up Guardian **Date completed**: 2023/07/03			

6. References

Freedom to Speak Up policy for the NHS, (June 2022) https://www.england.nhs.uk/wp-content/uploads/2022/04/B1245_ii_NHS-freedom-to-speak-up-guide-eBook.pdf

7. Acknowledgements

NHS England- The National Speak Up Policy

Part 2 – How to "Speak up"

What can I Speak Up about?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality):

1. Absence Policy
2. Change Management Procedure
3. Dealing with Relationships at work
4. Dignity and Respect at Work Policy
5. Disciplinary Policy
6. Employee Performance Improvement
7. Investigations Policy
8. Recruitment and Selection Policy
9. Work Life Balance Procedures
10. Management of incidents and serious incidents requiring investigation & learning policy.

As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

We want you to feel safe to Speak Up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

Who can workers speak up to?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. The organisation strives for a culture where that is normal, everyday practice and encourage all workers to explore this option – it may well be the easiest and simplest way of resolving matters.

There are other options in terms of who you can speak up to, depending on what feels most appropriate and depending on the site you work at.

The options listed below are available to all workers within our organisation:

- Senior manager, business partner, or director with responsibility for the subject matter you are speaking up about.
- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality). You can contact Margaret Mary Devaney, Director of Quality, email margaret.devaney@nhs.net or Dr Jon Bramall, Associate Medical Director for Patient Safety and Quality, email jon.bramall@nhs.net
- Our Freedom to Speak Up Guardian [Sylvia Gomes, email: Sylvia.gomes1@nhs.net, mobile 07388951067], who can support you to speak up if you feel unable to do so by other routes. Sylvia Gomes will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here.
- Local counter fraud team (where concerns relate to fraud), you can contact Hannah Wenlock, email: hannah.wenlock@tiaa.co.uk
- Human Resources related issues, Employee Relations Advisory Service (ERAS) can be contacted on ext: 5757 or email: enh-tr.erassupport@nhs.net
- Our senior lead responsible for Freedom to Speak Up is Theresa Murphy, Chief Nurse, email: theresa.murphy4@nhs.net. Theresa provides senior support for our speaking-up guardian and is responsible for reviewing the effectiveness of our FTSU arrangements.

- Our non-executive director responsible for Freedom to Speak Up is Val Moore, email val.moore@nhs.net. Val provides more independent support for the guardian including provision of a fresh pair of eyes to ensure that investigations are conducted with rigor; and will help escalate issues, where needed.

Speaking up externally

If you do not want to speak up to someone within your organisation, you can speak up externally to:

• Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.

• NHS England for concerns about:

- GP surgeries

- dental practices

- optometrists

- pharmacies

- how NHS trusts and foundation trusts are being run
(this includes ambulance trusts and community and mental health trusts)

- NHS procurement and patient choice

- the national tariff.

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix 2 contains information about making a ‘protected disclosure’.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

• **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.

• **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

• **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

You can Speak Up anonymously via our Trust incident reporting system ENHance or via Work in Confidence web platform https://secure.workinconfidence.com/company/en/signin/

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Advice and support

You can find out about the local support available to you at our Trust Intranet page.

Employee Relations Advisory Service (ERAS) can be contacted via Ext 5757

Health at Work, Tel No: 01438 286514

Here For You, Tel No: 03442573960

Staff Side (Union Reps)

Your local staff networks can be a valuable source of support and can be contacted via email:

Black Asian Minority Ethnic (BAME) Network, mail bamenetwork.enh-tr@nhs.net

Staff Carers Network Email: staffcarersnetwork.enh-tr@nhs.net,

Disabled members network. Email: disabilitynetwork.enh-tr@nhs.net,

LGBTQ+ network. Email: lgbtqplusnetwork.enh-tr@nhs.net

Women's Network. Email: womensnetwork.enh-tr@nhs.net

You can access a range of health and wellbeing support via NHS England:

• Support available for our NHS people.

• Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support. You can also contact the following organisations:

• Speak Up Direct provides free, independent, confidential advice on the speaking up process.

• The charity Protect provides confidential and legal advice on speaking up.

• The Trades Union Congress provides information on how to join a trade union.

• The Law Society may be able to point you to other sources of advice and support.

• The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment will be managed under our organisation's bullying and harassment policy. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix 1.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

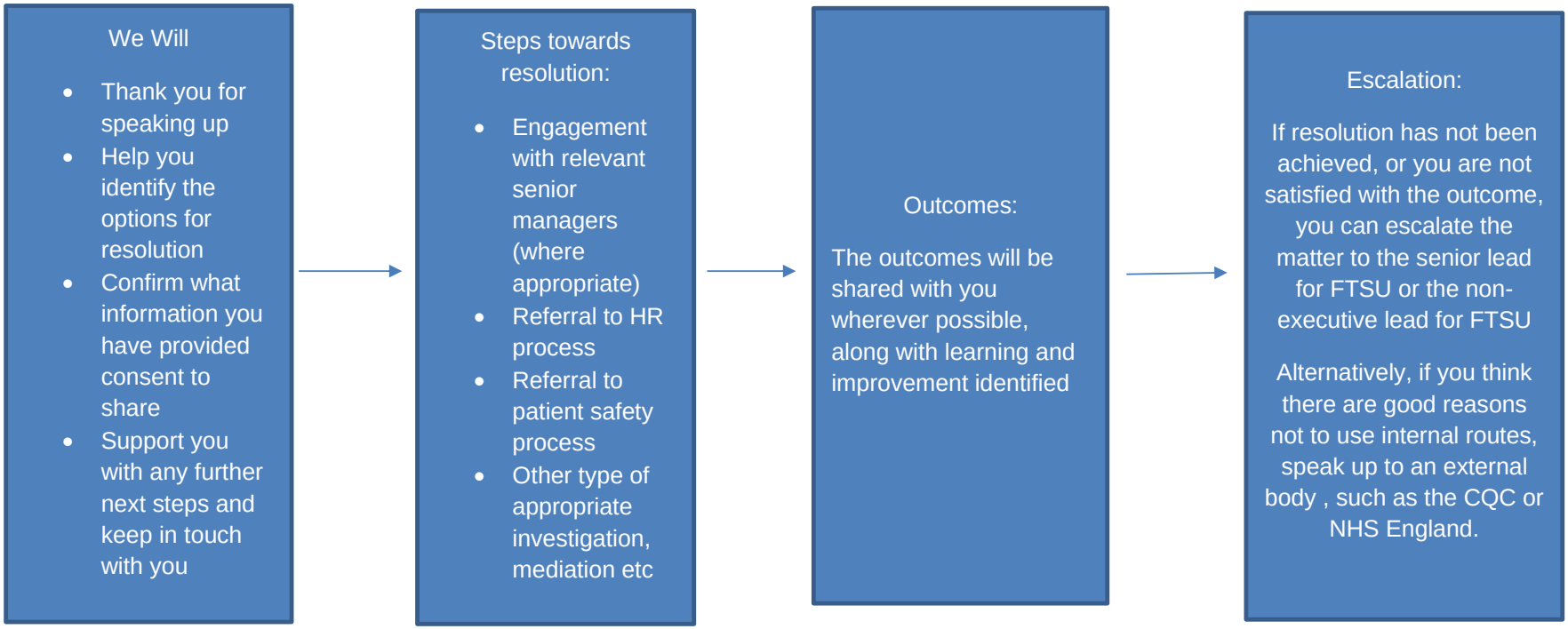
We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

Senior Leaders' Oversight

Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

Part 3 – Appendices

Appendix 1 – What will happen when I speak up?

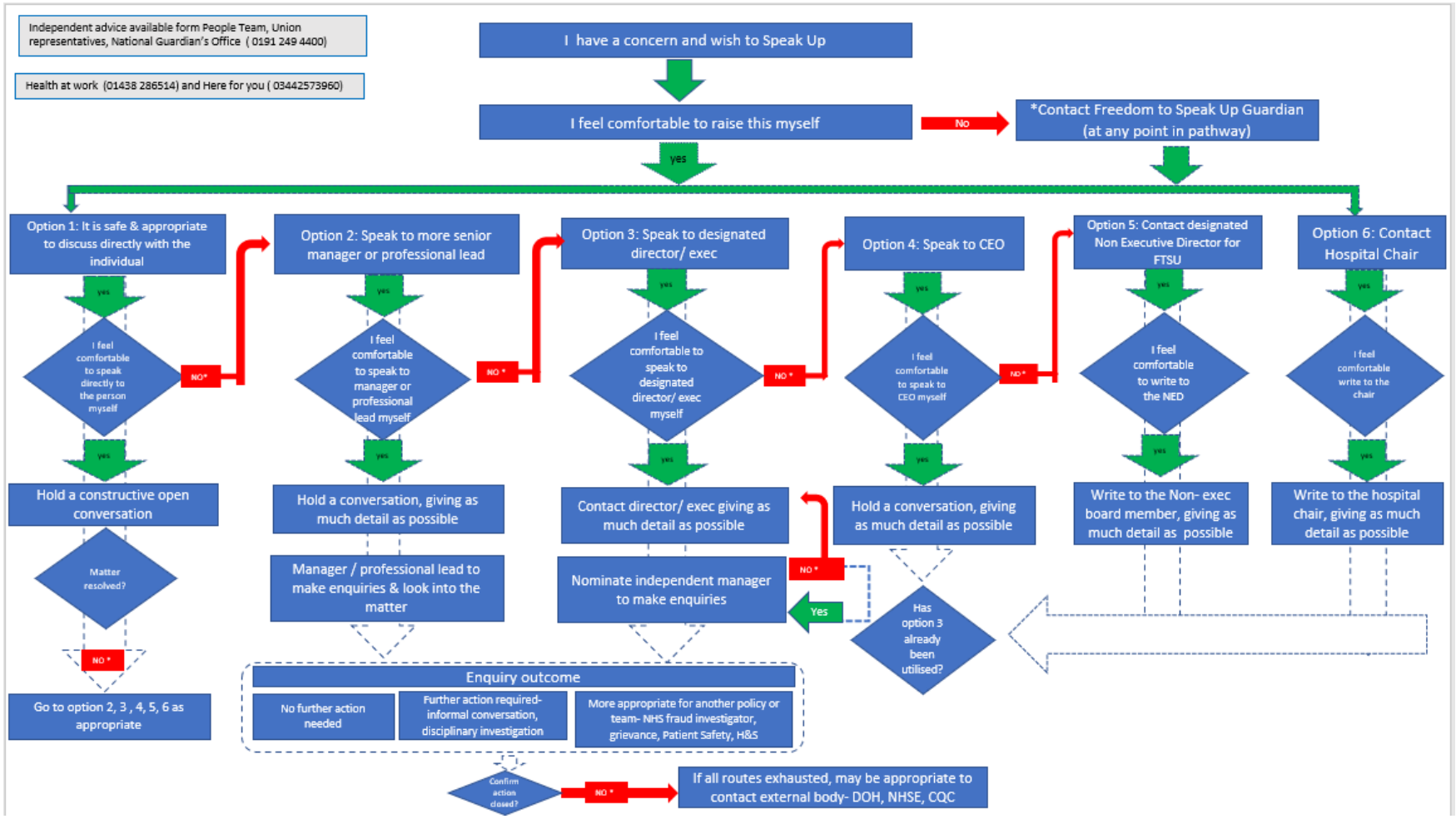


Appendix 2 – Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.

Appendix 3- FTSU Flowchart



PART 4 - Document record

As per policy **CP 116 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001 (Version 2)**.

Document info	Doc ID: CP 304 Version – 001 Speaking Up Policy This version is using TMP 001 – April 2023
Document type	Select one option: ☐ Guideline, ☐ Pathway, ☒ Policy,☐ Procedure, ☐ Protocol, ☐ Standard Operating Procedure **Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Other: **Input your selection here:** **For use Trust wide by all roles at all sites**
Review cycle	☒ Every 3 years (standard) ☐Annual review ☐ Other: **Insert date of next full review 31 MMMM YYYY**
Version type	SELECT ONE ☒New document – full consultation and endorsements ☐Full review of document - various amendments/ complete re-write ☐Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **New document – full consultation with endorsements** Select the appropriate sign-off category ☒TYPE A (full review requires 1 endorsement and approval) ☐TYPE B (interim update) ☐TYPE C (local use): Endorser + approver required **TYPE A – endorsement & approval required**
Keywords	
Version author/owner	Name, role, dept/service/area ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☐Corporate/Directorate
Document classifications	Please select all that apply to this document

	☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☐ **Forms** - This document contains forms in use at the Trust ☐ None of the above

Consultation & review

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust policies require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document See Equality, Diversity & Inclusion section of the intranet for details and the form. This step could take **3 to 4 weeks**. It is advisable to start the process at the initial stages and share a draft for review. EIA approval (supplied via email): Click or tap to enter a date.
2. Clinical Ethics Committee	This document may contain content that is contentious or raises moral debate. ☒No – proceed to next item ☐Yes – please see following actions **Step 1**: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation:
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust.

Trust stakeholder	Action required by author
	☒No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: TPC requires sign off on the final file and will be the final approver in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☒No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Nursing, Midwifery, AHP Quality Committee and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☒No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☐No – proceed to next item ☒Yes

Trust stakeholder	Action required by author
	Step 1: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement.
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☒No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☒No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☒No – proceed to next item ☐Yes

Trust stakeholder	Action required by author
	Step 1: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1** **Divisions (clinical areas)**: Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical director is apprised at that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record. **Step 2** In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (ie date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document.

11.1 List of document stakeholders

Document stakeholder	Date	Activity type
[insert name/ committee / group] ☐**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☐Other:
[insert name/ committee / group] ☐**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☐Other:
[insert name/ committee / group] ☐**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☐Content contribution ☐Read and agree fit for use ☐Other:

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☐At least one of the above in the consultation list is a formal endorser in the Record of agreement.
☐I understand an endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Other consultation and stakeholder actions required

[Some departments may have additional requirements for their policies and other controlled documents, which can be stipulated here.

If no content for this area, please indicate “Not applicable”.]

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **CP 116 - Trust policies and procedural documents**.

DOC ID & title	CP 304, Version: 001 - Speaking Up Policy
Due date of next full review	[expiry date]
Document type	Policy
Version type	New document – full consultation with endorsements
Applicability	For use Trust wide by all roles at all sites
Version author	Name, role, dept/service/area
Sign-off type	TYPE A – endorsement & approval required

Endorsement	Record of formal agreement this version is fit for use at the Trust by **[Insert committee/group or Trust function stakeholder's name, role, dept]** (delete as appropriate) is supplied in email dated **YYYY-MM-DD /** is in meeting minutes/ meeting action log under item [**insert reference number**], held on **YYYY-MM-DD**.
DELETE THIS ROW IF NOT REQUIRED FOR THIS SIGN OFF TYPE **Additional endorsement**	Record of formal agreement this version is fit for use at the Trust by **[Insert committee/group or Trust function stakeholder's name, role, dept]** (delete as appropriate) supplied in email dated **YYYY-MM-DD /** is in meeting minutes/ meeting action log under item [**insert reference number**], held on **YYYY-MM-DD**.
Trust endorsement for policies only	Record of formal agreement this version is fit for use at the Trust by **Policy Compliance Group** under action log item [**insert reference number**] at meeting held on **YYYY-MM-DD**.
Approval	Upon considering the above endorsements, the approver* [Insert name of approver, as identified in formal sign-off process for doc owner's area] agrees this document is fit for use at the Trust. Confirmation of this agreement (delete as appropriate) is supplied in email dated **YYYY-MM-DD /** is in meeting minutes/ meeting action log under item [**insert reference number**], held on **YYYY-MM-DD**.
Governance checks	ADMIN USE ONLY

*Types of **approvers** (as per policy CP 116):

- A committee/group or Trust function stakeholder's name, role, dept can approve a **fully reviewed** document
- A head of service, or stakeholder or committee chairperson (usually endorser 1 listed at the last full review) can approve an **interim update** of a document
- A head of service or department can approve documents for **local use only** (for all version types)
- All policies require "additional endorsement" from the Policy Compliance Group.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Trust Board		**Agenda Item**	12
Report title	Patient Safety Incident Response Framework Policy		**Meeting Date**	6 September 2023
Presenter	Assistant Director of Quality and Safety & Associate Medical Director for Patient Safety			
Author	Assistant Director of Quality and Safety & Associate Medical Director for Patient Safety & Associate Director of Governance			
Responsible Director	Chief Nurse and Medical Director		**Approval Date**	31/8/23
Purpose (*tick one box only)* [See note 8]	**To Note**	☐	**Approval**	☒
	Discussion	☐	**Decision**	☐

Report Summary:

This a new policy has been written to describe the Trust approach to learning and responding to patient safety incidents. Key notes form the policy include:

- The patient Safety Incident Response Framework (PSIRF) is a core element of the NHS Patient Safety Strategy approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care, to ensure Safety Standards are achieved. The safety standards are:
- Robust delivery of PSIRF requires a degree of training to ensure that those conducting learning reviews – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.
- Engagement and partnership working with patients, families and staff involved in incidents is paramount through learning responses and improvements.
- This policy may be reviewed within the 1st 12months as learning and continuous improvements are experienced through adoption of policy recommendations.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

This will be supported by new reporting structure and add value a more robust internal systems approach to learning and improving form incidents.
This will support and encourage an improved speaking up culture and involvement of staff involved in incidents.

Risk: *Please specify any links to the BAF or Risk Register*

Staff capability and approach to innovation.
Public trust within the services we deliver, and codesign of improvements.

Report previously considered by & date(s)

Executive round table, August 2023

Recommendation	The Board/Committee is asked to approve policy.

To be trusted to provide consistently outstanding care and exemplary service

DOC ID:
CP 310

East and North Hertfordshire NHS Trust

Patient Safety Incident Response Framework

About this document	
Document ID	CP 310 **Version:** 001
Full review due before	01 October 2024 – reviewed annually
Document type	Policy
Usage & applicability	For use Trust wide by all roles at all sites

Summary

- The Patient Safety Incident Response Framework (PSIRF) is a core element of the NHS Patient Safety Strategy approach to the development and maintenance of mechanisms for responding to patient safety incidents (PSIs) to maximise learning and improvement.
- The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care. Robust delivery of PSIRF requires a degree of training to ensure that those conducting learning reviews – as well as those providing oversight of the process – have an adequate level of knowledge and experience to ensure that investigations lead to learning and improvement.
- This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out East and North Herts NHS Trust's (the Trust) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

What you need to know about this version

VERSION TYPE: **New document – full consultation and endorsements**

This is a new policy document in line with national guidelines. This document outlines the national framework for incident investigations and replaces investigation processes previously used at ENHT.

Document control info and governance record in "PART 4 - Document information"
Disclaimer: This document is uncontrolled when printed. See intranet for latest version.

Contents

Part 1 – Preliminary document information

1. Scope

This policy, written in line with current national guidelines, is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based human factors approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single and/or isolated component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', is stated as the cause of an incident.

Where other processes exist with a remit of determining liability or the apportion of blame, or cause of death, the principal aim would necessarily differ from a patient safety response. Such processes as listed below are therefore outside of the scope of this policy.

- claims handling
- human resources investigations into employment concerns
- professional standards investigations
- information governance concerns
- estates and facilities concerns
- financial investigations and audits
- safeguarding concerns
- coronial inquests and criminal investigations
- complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes are separate from any patient safety investigation. Information from a patient safety response process can be shared with staff/colleagues leading other types of responses, however, these processes should not in any way influence the remit of a patient safety incident response.

2. Purpose

The Patient Safety Incident Response Framework (PSIRF) is a core element of the NHS Patient Safety Strategy approach for the development and maintenance of mechanisms (systems and processes) for responding to patient safety incidents (PSIs) to maximise learning and improvement.

The PSIRF is a contractual requirement and is mandatory for providers of NHS-funded care. Robust delivery of PSIRF requires a degree of training to ensure that those conducting learning reviews – as well as those providing oversight of the process – have the necessary and required level of knowledge, expertise and experience that supports effective robust investigations leading to Trust-wide learning and improvement.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out East and North Herts NHS Trust's (the Trust) approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated data and information driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

Our patient safety incident response policy is an overarching policy for patient safety management in our organisation. The policy includes details of relevant aspects of incident management in our organisation, including patient safety incident reporting and safety improvement monitoring.

This policy supports development and maintenance of an effective patient safety incident response process that integrates the four key aims of PSIRF which is aligned to East and North Hertfordshire NHS Trust values- Include, Respect and Improve:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement

This policy should be read in conjunction with our current [patient safety incident response plan], which is a separate document suite of relevant standard operating procedures (SOP) which sets out how this policy will be implemented.

3. Definitions

Below is a list of abbreviations frequently used throughout the document.

AAR	After action review
AfC	Agenda of Change
DOC	Duty of Candour
DSIRP	Divisional Safety Incident Response
ICB	Integrated Care Board
IPC	Infection Prevention and Control
KPO	Kaizen Promotion Office
LFPSE	Learning from patient safety event
MDT	Multi-disciplinary Team
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety
PSP	Patient Safety Partner
QM	Quality Management
RJLC	restorative, just and learning culture
SIRP	Safety Incident Response Panel
SOP	Standard Operating Procedure
TEL	Technology Enhanced Learning
VMI	Virginia Mason Institute

4. Duties

CEO	Ensure ENHT systems and structures support delivery of high performing PSIRF safety standards
Director of Improvement	Ensure improvement capabilities accessible and sustainable
Medical Director	Accountable officer for PSIRF safety standards
Chief Nurse	Accountable officer for PSIRF safety standards
Director of Operations	Ensure ENHT systems and structures support delivery of high performing safety standards
Director of Quality	Deputy responsible officer for ensuring systems and structures support the delivery of high performing safety standards
Associate Medical Director PS	Deputy responsible officer for ensuring ENHT systems and structures support the delivery of high performing safety standards
Chair QSC	Responsible for overseeing and seeking assurance that systems and structures support the delivery of high performing PSIRF safety standards
AD capability	Responsible for ensuring capability building plans provide ENHT systems and structures with requirements to meet PSIRF safety standards
AD Quality Governance	Responsible for ensuring compliance and

	assurance within systems and structures can be monitored against PSIRF safety standards
Head of Quality Improvement	Responsible for ensuring all learning & Liaison responses influence and drive continuous improvement across all levels. Ensure processes and support infrastructure delivers meaningful engagement of staff and patients involved in incidents
Patient Safety Programme Lead	Responsible for ensuring all PSIRF Improvement priorities are cohesive and effective, overseeing a number of multidisciplinary improvement projects in line with the quality and trust objectives of the organisation and national patient safety priorities.
Learning response and liaison leads	Responsible for ensuring all incidents have proportionate responses that meet PSIRF safety standards, including meaningful engagement of staff and patients involved in incidents
Patient Safety & Legal Governance Lead	Responsible for ensuring all PSIRF safety standards and externally reporting mechanisms are reliable and meet PSIRF safety standards
Divisional Quality Managers	Responsible for ensuring compliance and assurance within systems and structures can be monitored against PSIRF safety standards
Divisional Director(s) of Nursing	Divisional responsible officer for ensuring systems and structures support the delivery and oversight of high performing safety standards.
Divisional Medical Director	Responsible for ensuring divisional systems and structures support the delivery and oversight of high performing safety standards.
Divisional Operational Director	Responsible for ensuring divisional systems and structures support the delivery and oversight high performing safety standards.
Clinical Directors	Responsible officer for ensuring systems and structures support the delivery and oversight of high performing safety standards.
Matron and operational managers	Responsible for ensuring operational services level systems and structures support the delivery and oversight of high performing safety standards
Ward manager/ another team leader	Responsible for ensuring unit level systems and structures support the delivery and oversight of high performing safety standards

5. Associated Documents

The following documents are related Trust policies and procedural documents, which are advised reading to supplement this document and/or process. These items are different to the titles listed in Part 1 References, which contains external resources referenced in the development of this document.

Document title	Doc ID	Originator
Management of complaints and concerns policy	CP 306	☒ENHT | ☐Affiliated network | ☐National/ regional
Duty of Candour policy	CSEC 010	☒ENHT | ☐Affiliated network | ☐National/ regional
PSIRF Plan	TBC	☒ENHT | ☐Affiliated network | ☐National/ regional

6. Monitoring compliance

This document will be reviewed **annually** or as determined by changes in processes that supports the effective investigations of incidents and/or where any evidence or change in practice comes to light requiring an update to the document.

Any further activity to monitor to the use and compliance of the document at the Trust is documented below.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy, planning and oversight	Annual PSIRF plan shall be published every 12 months. Audit of adherence to standardised governance reporting of application of PSIRF learning responses, PSII learning reviews. PSIRF Improvement priorities shall be tracked through SIRP and KPO	Director of Quality Patient Safety Lead	Shared annually with Trust Board ICB & PLACE	
Compassionate engagement and involvement of those affected by patient safety incidents	Survey methods shall be designed to be utilised through routine engagement processes with staff, patients and families Staff, patient and family stories shall be shared. Monthly sample audit of DOC application	TBC	Quality and Safety Committee Quarterly Trust Board Bi-monthly ICB & PLACE	
Competency and capacity to apply of a range of system-based approaches to learning from patient safety incidents.	Measure compliance with essential national safety training modules Number of staff trained in PSIRF oversight roles. Number of staff capable to undertake Learning		Quality and Safety Committee monthly People committee monthly	

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
	reviews (AAR, MDT Round tables, Debriefs) Number of staff trained in SEIPS model (PSII) Number of staff undertaking Msc Patient Safety		Trust Board Bi-monthly ICB & PLACE	
Considered and proportionate responses to patient safety incidents	A count of SEIPS learning response models deployed shall be measured monthly. Sample audit documented risk-based approach to decision making shall be captured through DSIRP and SIRP		Quality and Safety Committee monthly Trust Board Bimonthly ICB & PLACE	

This policy shall support the delivery of NHSE Safety Incident Response Safety Standards

Compliance with this policy shall be demonstrated through learning and improvement oversight structures through unit, service and divisional learning and improving structures.

Evidence shall be provided to demonstrated compliance against the key standards

6.1. Equality Impact assessment

The Trust supports the practice of evidencing due regard to equality considerations. This means those involved have ensured the document and the function, outlined therein, applies to all, regardless of protected characteristic - age, sex, disability, gender-re-assignment, race, religion/belief, sexual orientation, marriage/civil partnership and pregnancy and maternity.

This evidence is in the form of an equality impact assessment (only if initial screening form below prompts a full EIA) – a process which should be embedded within the early stages of planning or developments that relate to or impact on equality diversity and inclusion. This also applies to new proposals or changes on previous policy, procedure, strategy or processes that are coming up for review. More on this process for completing Equality Impact Assessments can be found on the Equality, Diversity & Inclusion section of the intranet.

Initial EIA screening form

The document author has ensured the policy/guideline avoids affecting one group less or more favourably than another on the basis of:		**Impact Yes/ No**	**Comments**
1	Age (younger people & children & older people)	No	
2	Gender (men & women)	No	
3	Race (include gypsies and travellers)	No	
4	Disability (LD, hearing/visual impairment, physical disability, mental illness)	No	
5	Religion/Belief	No	
6	Sexual Orientation (Gay, Lesbian, Bisexual)	No	
7	Gender Re-assignment	No	
8	Marriage & Civil Partnership	No	
9	Pregnancy & Maternity	No	
10	Is there any evidence that some groups maybe affected differently?	No	
11	Could this document have an impact on other groups not covered by a protected characteristic? (ie: low wage earners or carers)	No	
Any other comments: There is no evidence that this policy will impact on any of the protected characteristics listed above, or other groups not covered by protected characteristics.			
EIA screening form completed by: Director of Quality **Date completed**: 2023-08-30			

7. References

National patient Safety Strategy (2021) https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

Patient safety Incident Response framework (2022) https://www.england.nhs.uk/patient-safety/incident-response-framework/

Equality Act (2010) https://www.legislation.gov.uk/ukpga/2010/15/contents

LFPSE https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/

Safety action development guide (2022), NHSE https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

8. Acknowledgements

The development of this policy has been done through collaborative working from key staff members, particularly:

- Bridget Sanders, Medical Programme Director
- Tracey Van Wyk, Head of Quality Improvement
- Dr Jon Bramall, Associate Medical Director, Patient Safety Specialist
- Rachel Bulloch, Patient Safety Pharmacist, Patient Safety Specialist
- Namdi Ngoka, Associate Director People Capability
- Michelle Anstiss, PSIF project lead
- Margaret Mary Devaney, Director of Quality
- Sarah Simmons, Deputy head of Communication
- Chris Curtis, Patient Safety Partner
- Margaret Okojie, Associate Director of Quality Governance
- Rosie Connolly, Deputy Director of Quality Improvement & Patient Safety, Hertfordshire and West Essex ICB
- National and Regional Patient Safety Specialist networks
- NHSE Patient Safety Incident Response networks and platforms

Commented [OM(ANHNT1]: Please include any collaboration with external stakeholders or resources used from an external organisation.

Part 2 – Framework

Our patient safety culture

East and North Hertfordshire NHS Trust is in the initial stages of introducing a different approach to the manner, in which we manage and learn from patient safety incidents and incidents related to employee relations. Our ambition is to establish a restorative, just and learning culture (RJLC) within the organisation, one that promotes no blame, psychological safety and quality improvement.

A crucial step in the development of our RJLC patient safety culture has been the introduction of our new Trust values of “Include, Respect and Improve” and the expectation that all our people model locally agreed expected team behaviours.

As we introduce PSIRF, we will ensure that the following key elements are incorporated:

- leadership
- teamwork
- communication
- restorative, Just and Learning Culture (RJLC)
- psychological safety
- promoting inclusion and diversity
- staff well-being
- civility and kindness initiative
- organisational and leadership development through a “healthy teams” approach

We plan to upskill staff to understand and support our restorative, just and learning culture ambitions, ensuring that our procedures and policies are suitable, and that line managers and senior clinicians are competent to support staff through the patient safety response framework process appropriately.

Our local Trust priorities include communication and encouraging civility, so there will be a focus in trying to learn and improve from these types of incidents.

We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at the identified learning and improvement whilst increasing transparency and openness amongst our staff in reporting of incidents. This will include identifying insight from when things have gone well and where things have not gone as planned.

To enhance our safety culture, we have introduced safety huddles at all levels of the organisation which consider risks emerging or known and the insight offered from incidents that have occurred and an opportunity to share learning.

We will use the findings from our staff survey metrics based on specific patient and staff safety questions to assess if we are progressing in improving our safety culture, as well as using specifically designed patient safety culture questionnaires.

Patient safety partners

A patient safety partner is a role that is new and evolving. The purpose is for our service users, be they patients, carers or family members to use their lived experience to work with the Trust to improve our safety culture and systems as an equal member of the team.

A 'Patient Safety Partner' (PSP) is defined for the purposes of this policy as: a person that supports effective safety governance and improvement within an organisation by working in partnership with staff. They will be asked to provide a different perspective on patient safety which is not influenced by organisational bias or historical systems, resulting in a patient-centred approach to safer healthcare. This group of people will be a voice for patients and the community ensuring that patient safety is a priority for the organisation at all levels.

PSPs could be required to participate in any of the following activities:

- support the design of the patient safety plan and this policy in conjunction with the Patient Safety Specialist or delegated lead
- PSPs may work with the board and its members to consider how to improve safety
- PSPs may be involved in patient safety improvement projects
- PSPs may be asked to act as a mentor or 'buddy' for new PSPs joining the Trust
- PSPs may be asked to be involved in staff patient safety training
- PSPs may be asked to participate in investigation oversight groups

PSPs will be offered the following:

- Remuneration on a sessional basis.
- Ongoing support from the patient safety specialist.
- Opportunities for further training in relation to designated role identified in line with the requirements of the individual in conversation with a Patient Safety Specialist.
- A signed involvement agreement with the Trust, detailing mutually agreed commitments (reviewed on an annual basis alongside a grow together conversation to identify ongoing training and support needs).
- As this is a new and evolving role for the Trust, the Role Description is likely to adapt and change so duties will be subject to change (as specified within the Role Description). Early review in consultation with the PSP, Service Lines and the Patient Safety Specialist will be key to the success of the role.

Addressing health inequalities

Health inequalities can be defined as systematic, unfair and avoidable differences in health across the population, and between different groups in society. East and North Hertfordshire NHS Trust recognises that we, in collaboration with the Integrated Care Board, have a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust as a public authority is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics.

We will directly address as part of our response any features of an incident which indicate that health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

We will also address apparent health inequalities as part of our safety improvement work. In establishing our PSIRF plan, we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of our patient safety incident response plan and this policy.

Engagement of patient, families and staff following a patient safety incident is critical to the review of patient safety incidents and their response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and respond to any questions/queries they have in relation to the incident and signpost them to support as required.

The Trust is committed to co-production and **include** patients, families and staff in learning responses, **respect** recognise and acknowledge their voice in the learning process and continuously **improve** the care, experience and service we provide. We will ensure that all accessible needs are met and that an individualised approach will be taken depending on individual's needs.

As a Trust we advocate being open and transparent with our patients, families, carers and staff alongside our statutory and regulatory Duty of Candour obligations. As part of our Duty of Candour process, we will be collaborative and open with all those affected and involved in a patient safety incident. The Trust recognises the importance of compassionate engagement in all our learning responses.

We will clearly outline procedures that support patients, families, carers and staff based on our existing Duty of Candour policy. These will include a leaflet for patients, guidance notes for staff and template letters. This will ensure that the 4 required steps of engagement are met; 1) before contact, 2) initial contact 3) continued contact and 4) closing contact.

The Trust will support and deliver an operational plan that provides a supportive and candid liaison relationship between all staff, families and carers and patients involved in patient safety incidents.

This liaison infrastructure shall guide patients, families and carers through the expectations of any learning review undertaken, ensuring that they have the opportunity to be involved in the learning process and be able to contribute to lessons learnt and/or seek support where required.

There may be occasions when other external responses are ongoing alongside a patient safety incident review. These may include litigation, an Inquest, Healthcare Safety Investigation Branch (HSIB), Police investigations or Social Services. In such instances, the patients, families, carers or staff should be made aware of these and provided with relevant contacts.

We recognise there are also other forms of support outside of the Trust that can help those affected by a Patient Safety Incident and we will work with patients, families, carers and staff to signpost them accordingly. For example bereavement charities, advocacy services and Healthwatch Hertfordshire.

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising learning and improvement.

To fulfil this, we will align current resources for patient safety incident responses and safety improvement.

We will identify insight from our patient safety incidents and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

Resources and training to support patient safety incident response

The Trust has committed to ensuring that we fully embed the PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required for all our staff including specific training for those involved in patient safety incidents.

The Trust will have in place governance arrangements to ensure that learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division. A learning response lead will be nominated by the Division and the individual should have an appropriate level of skills and experience to competently lead the learning response required.

The Trust will have governance arrangements in place to ensure that learning responses are not undertaken by staff working in isolation.

Those staff affected by patient safety incidents will be afforded the necessary restorative support and be given time to participate in learning responses and improvements.

All Trust managers will be supported to develop capabilities that enable the delivery of just culture principles in line with our Trust values.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response and improvement processes to provide expertise (eg , clinical, or human factors review). The Trust has an improvement partnership with Virginia Mason Institute (VMI). This will deliver targeted and measurable capability programmes.

Training

The Trust has implemented a suite of patient safety training packages to ensure that staff/colleagues are aware of their responsibilities in reporting and responding to patient safety incidents and to comply with the NHS England Health Education England Patient Safety Training Syllabus as follows

- Level one
    - national – Health Education England patient safety syllabus module (Essentials for patient safety)
    - all staff, clinical and non-clinical are expected to undertake these on induction and to repeat every three years
    - these modules are available as eLearning via ENH Academy access
    - national – Health Education England patient safety syllabus module (Essentials of patient safety for boards and senior leadership teams
    - this module can be accessed directly from the ENH Academy platform
- Level two
    - national – Health Education England patient safety syllabus module (Access to Practice) – this is to be undertaken by all medical staff and staff on Agenda for change (AfC) bands 5 and above, with potential to support or lead patient safety incident management
    - this module is available as eLearning via ENH Academy

Learning response leads training and competencies

- Training
    - Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response. Records of such training will be maintained by the Learning and Development

Technology Enhanced Learning (TEL) team as part of their general education governance processes.
  - Learning response leads must have completed Level one and two of the national patient safety syllabus.
  - Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.
  - To maintain expertise the Trust will undertake an annual networking event for all learning response leads.
  - Learning response leads will need to contribute to a minimum of two learning responses per year.

- Competencies
  As a Trust we expect that those staff leading learning responses are able to

  - Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
  - Summarise and present complex information in a clear and logical manner and in report format.
  - Manage conflicting information from different internal and external sources.
  - Communicate highly complex matters and in difficult situations.

  Support for those new to this role will be offered through the Trust's Learning Response and Improvement Lead and through the VMI capability programme

Engagement and involvement training and competencies

- Training

  - Engagement and involvement with those affected by a patient safety incident will be undertaken by those who have undergone a minimum of six hours training, including **Involving patients, families and staff in patient safety incidents** (this covers areas such as the Duty of Candour training, challenges and complexity and dealing with conflict).
  - Records of such training will be maintained by the Learning and Development Technology Enhanced Learning (TEL) team as part of their general education governance processes.
  - Engagement leads must have complete Level one and two of the national patient safety syllabus.
  - Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.
  - To maintain expertise the Trust will undertake an annual networking event for all engagement leads.
  - Engagement leads will need to contribute to a minimum of two learning responses per year.

- Competencies
  As a Trust we expect that those staff who are engagement leads to be able to

    - Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
    - Listen and hear the distress of others in a measured and supportive way.
    - Maintain clear records of information gathered and contact those affected.
    - Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
    - Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Oversight roles training and competencies

- Training

    - All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents. Records of such training will be maintained by the Learning and Development Technology Enhanced Learning (TEL) team as part of their general education governance processes.
    - Those with an oversight role on our Trust Board and leadership team (ie, executive leads) must have completed the appropriate modules from the national patient safety syllabus - Level one - essentials of patient safety and essentials of patient safety for boards and senior leadership teams.
    - All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

- Competency

As a Trust we expect staff with oversight roles to be able to

    - Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
    - Apply human factors and systems thinking principles.
    - Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
    - Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.

- Recognise when safety actions following a patient safety incident response do not take a system-based approach (eg , inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report format.

Additional Learning for those involved in Patient Safety Responses

In addition to the above competences and training the Trust will provide the following additional support and learning to staff involved in our Patient Safety Incident Responses

- Use of System Engineering Initiative for Patient Safety (SEIPS) framework in all learning responses
- Human Factors training both theory and simulated learning
- Training on the use and application of the agreed Trust learning response tools – Patient Safety Incident Investigations (PSII), Roundtable/Multi-disciplinary Team (MDT), After Action Reviews (AARs) and hot debriefs.
- Duty of Candour, Psychological Safety and Just Culture learning
- Facilitation skills training - Theory and scenario based
- Quality Improvement –theory and application

Training will be made available via ENH Academy online training and classroom-based events including opportunities for lab based and in-situ simulation.

Our patient safety incident response plan

Our plan sets out how the Trust intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

[Patient Safety Incident Response Plan] can be found on the intranet.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will

review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our ICB) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

Patient safety incident reporting arrangements

Safety incident reporting arrangements

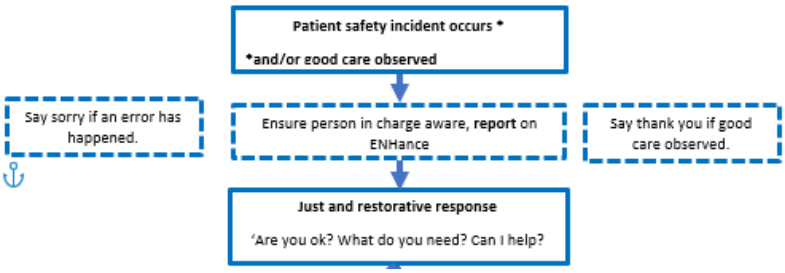
All staff are responsible for reporting any potential or actual patient safety incident or good care witnessed on ENHance which is the Trust's Quality Management system. ENHance includes incident reporting. ENHance is aligned with 'Learning From Patient Safety Events' (LFPSE) and thus enables automated uploading to national systems, as appropriate, in order to support national learning. More information on LFPSE can be found here: https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service/

As part of the incident reporting form, reporters are required to include detail of the level of physical harm and psychological harm that has been experienced by the person affected. The reporting form also provides the relevant prompt for when Duty of Candour applies to an incident and provides a section for the detail to be recorded. Being Open (Duty of Candour) Policy CSEC010 can be found on the intranet.

Local reporting

The nominated person in charge of clinical or non-clinical areas where a patient safety incident has occurred must be informed as soon as is viable from the time the incident occurred.

There must be clear identification of who shall report the incident in the reporting system ENHance, this should be done as soon as is viable from the time the incident occurred.



Ongoing review of incidents and good care reported

Staff in Quality Management (QM) and Learning Response and Liaison (LRL) roles must review the automatic report of 'daily incident report' on ENHance each day and should not rely on email notifications.

Divisional Directors of Nursing/Midwifery, as responsible officers within nominated divisions, will ensure daily review mechanisms are in place to ensure that reported patient safety incidents are responded to proportionately and in a timely manner.

The divisional clinical and quality governance teams will facilitate a safety incident response panel (DSIRP) to provide oversight and review of incidents reported and the application of the safety response standards. This will ensure staff and patients/family's needs have been met and Duty of Candour has been applied, where appropriate.

The DSIRP will also oversee the divisional safety action plan, stratified to unit and service level and seek high ranking evidence of assurance provided against each safety action.

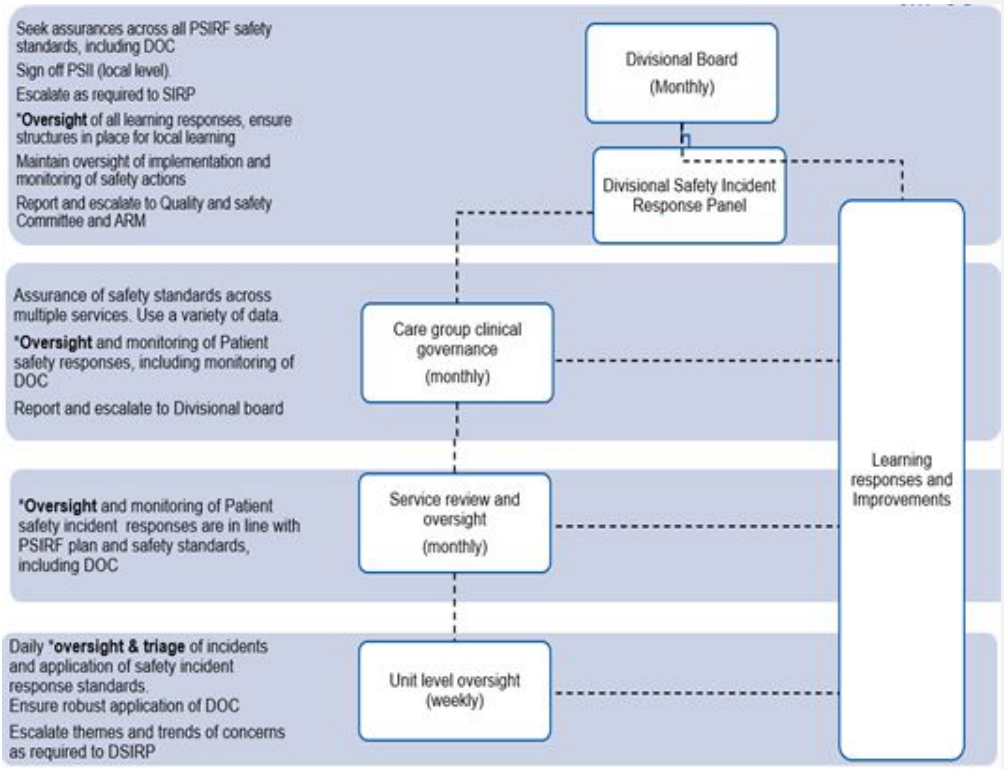
Reported incidents should be assessed at unit/area level, service/care group level, divisional level, hospital wide and system level for:

- assurance and evidence that the correct incident response has been applied and is proportionate.
- trends in reporting- looking for any hot spots, clusters (either geographically or subject similarity) and identify if normal and unwarranted variation present.
- any areas of poor/under reporting - should be explored to understand any potential reporting barriers.

The DSIRP must ensure:

- A variety of data is interrogated to ascertain appropriate response to incidents reported.
- Information collection is relevant and required, and data has clarity and purpose.
- Application of different tools and methods that are appropriate for incident reported -not 'one size fits all'.
- Visibility of meaningful insight from patients, families, and staff

Divisional Safety Incident Response Structures



A similar incident which may occur within a service/ discipline outside of the immediate remit of a prior investigation but falls within the scope of another subject matter expert shall be reported on ENHance and managed via/through an identified liaison for the local area with the relevant accountable service having oversight e.g. health and safety incidents will be managed through to the Health & Safety Executive, the Trust Health & Safety team will remain the liaison with HSE and the Health, Safety, Fire & Security Group would have oversight. This will enable the Trust to continue to meet all required reporting requirements and ensure oversight of relevant actions.

Sharing learning from reported incidents and good care

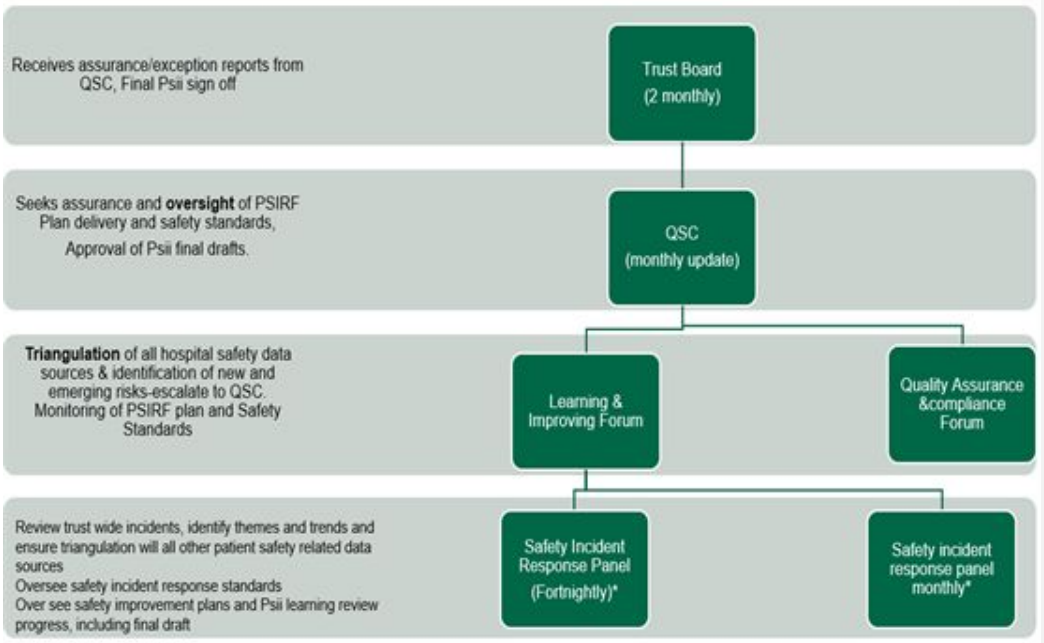
Learning from reported themes, trends, improvements and actions taken must be shared across services at ENHT.

A safety incident which appears to meet the requirement for reporting externally will be brought to Safety Incident Response Panel (SIRP) for discussion and oversight. This will allow the Trust to work in a transparent and collaborative way with the ICB, or other key stakeholders as required.

Learning from reported incidents shall be shared through the Trust Safety Incident Response Panel (SIRP). This will ensure oversight of the Trust-wide patient safety and risk profile and alignment with patient safety improvement actions/priorities and PSIIs.

SIRP will also oversee a trust wide safety action plan and seek high ranking evidence of assurance provided against each safety action.

Organisational Safety Incident Response Structures



Where the Coroner has requested for further information or statements for the purposes of an Inquest, the Claims and Inquests team will ensure any relevant patient safety incident learning is shared with the Coroner.

A strong operational process shall support cross-system learning with system partners through forums such as PLACE, Integrated Care Board oversight groups, regional quality system meeting and speciality forums eg End of Life, learning from deaths, and transformation groups.

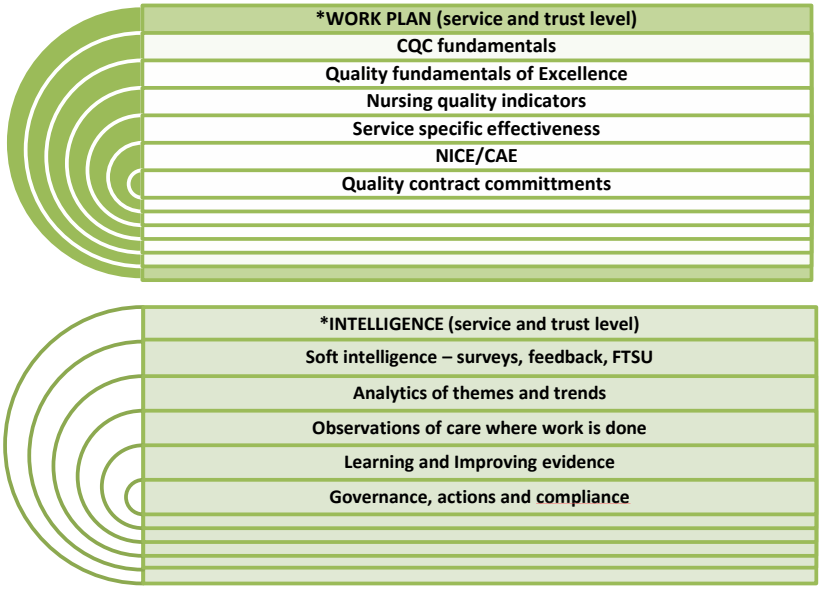
Patient safety incident response decision-making

Incidents shall be overseen by the Trust's Learning Response & Liaison leads.

Data is available online from the national surveys of staff and patients. These include inpatients, outpatients, maternity services and the staff survey. Each of these contains information about the safety of services. The staff survey contains questions relating to patient safety and from the results over time it is possible to

assess views on workload pressures, job-related training opportunities, violence, aggression and harassment, and the percentage of staff witnessing potentially harmful errors or near misses.

Safety cannot be seen in isolation from broader concerns about quality. Of necessity, safety is always only one consideration in a broader picture. Therefore, multiple factors potentially affect the safety and quality of care delivered to patients. The Trust Quality Assurance (QA) Framework should be used in alignment when considering responses to incidents. The QA Framework shall include:



A risk-based approach to appropriate response should be done through oversight and triangulation of key information such as:

- analysis of trends in safety data – looking for variation within the system
- a review of other safety critical information such as staffing level, vacancy rates, risk management, key operational performance data sets, availability of equipment, environmental conditions and all aspects of feedback
- learning from mortality reviews
- evidence of high reliability in processes through audits and study of where work is done
- oversight of relevant regulatory compliance and other externally regulated requirements.

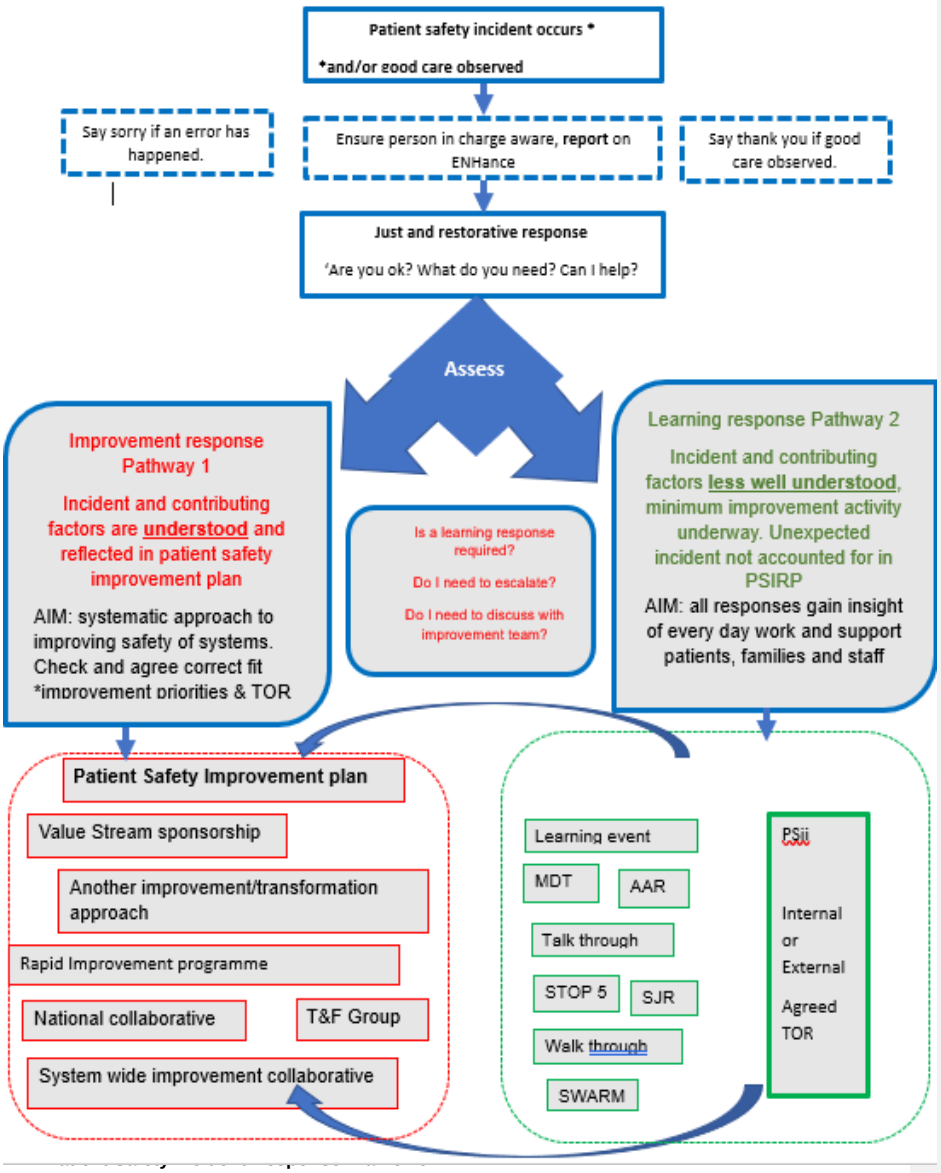
Where we recognise there are unknown aspects and more learning required a request shall be made to deploy recognised system-based methodologies for data collection and analysis e.g Systems Engineering Initiative for Patient Safety reviews (SEIPS), AAR, debriefing, mapping current and future states, undertake baseline audits or survey.

Responses shall ensure prompt and effective communication between those affected by a patient safety incident through governance structures of local oversight incident response frameworks.

Where risk has been identified to be significant a proportionate response should be deployed.

- after action reviews and debriefs
- MDT roundtable learning review
- safety improvement initiatives
- area specific task and finish groups
- inform existing PSII learning reviews
- inform existing improvement programmes

Incident Response Pathway



Responding to cross-system incidents/issues

The Trust is committed to collaborative engagement with all those affected by and involved with patient safety incidents.

The Trust will work with other NHS Trusts, relevant system care providers and stakeholders and ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents.

Where it is recognised that an incident requires a cross-system learning response, it will be escalated to the Trust SIRP from the DSIRP, and/or escalations from external sources to the Trust.

Through collaborative partnership working the Trust will proactively seek out learning opportunities e.g. with other providers, GPs, the local authority, Police, Ambulance Service etc. and welcome joint learning through structured learning responses such as:

- AARs and debriefs
- MDT roundtable learning reviews
- safety improvement initiatives
- PSII learning reviews
- structured incident task and finish groups

ENHT safety incident response structures seek proactive strong partnership working with ICB Quality & Safety structures to ensure cross system learning reviews e.g. MDT roundtable discussions are collaborative and facilitated to achieve meaningful learning and engagement of improvement/ actions.

Where cross-system incidents themes and emerging risks occur, ENHT will consider an executive and board agreement for a proposal and consideration with the ICB and systems partners, for deployment of an ENHT hosted quality improvement breakthrough series collaborative across willing partner providers and system partners.

Timeframes for learning responses

Timescales for Patient Safety Incident Investigation (PSII)

Criteria for a PSII shall be clearly defined in the ENHT annual PSIRF plan.

Where a PSII learning review is indicated, the investigation must be initiated immediately following SIRP acknowledgement that a PSII patient safety incident has been identified.

A PSII learning review shall agree targeted milestones and trajectories at the beginning of the learning review, agreed at the outset with the key stakeholders (including both those affected and those involved) as part of the setting of terms of reference.

The learning response lead shall ensure oversight of milestones through divisional learning and improving structures; and escalation via DSIRP & SIRP as required where milestones are at risk of not being met.

No local PSII should take longer than six months.

The Trust recognises that every learning response will require various depths of application of the SEIPIS learning model. A PSII learning review will require an extensive in-depth learning review and studying of systems where incidents have occurred, and a degree of flexibility of timescales will be required to ensure contributions of those involved and affected by the incident remain a priority and learning pace is compassionate and effective.

In exceptional circumstances a longer timeframe past 6 months may be required for completion of the PSII based on the individual, specific case e.g. where patient or family require more time to engage with the learning review. In such instances, any extended timeframe should be agreed between the interested parties and be noted at Safety Incident Response Panel. In the spirit of the PSIRF, these timescales will not become routine targets and the focus will remain on appropriate, impactful learning. However as per the above, having any extensions brought to the Safety Incident Response Panel will allow for oversight of the timeliness of the process and if the PSIIs are frequently taking longer than anticipated, the process will be reviewed to understand the reasons why and how this can be improved.

Timescales for other forms of learning response

A learning response must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of the date when the incident is reported. No learning response should take longer than six months to complete.

Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or other learning review) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, credible

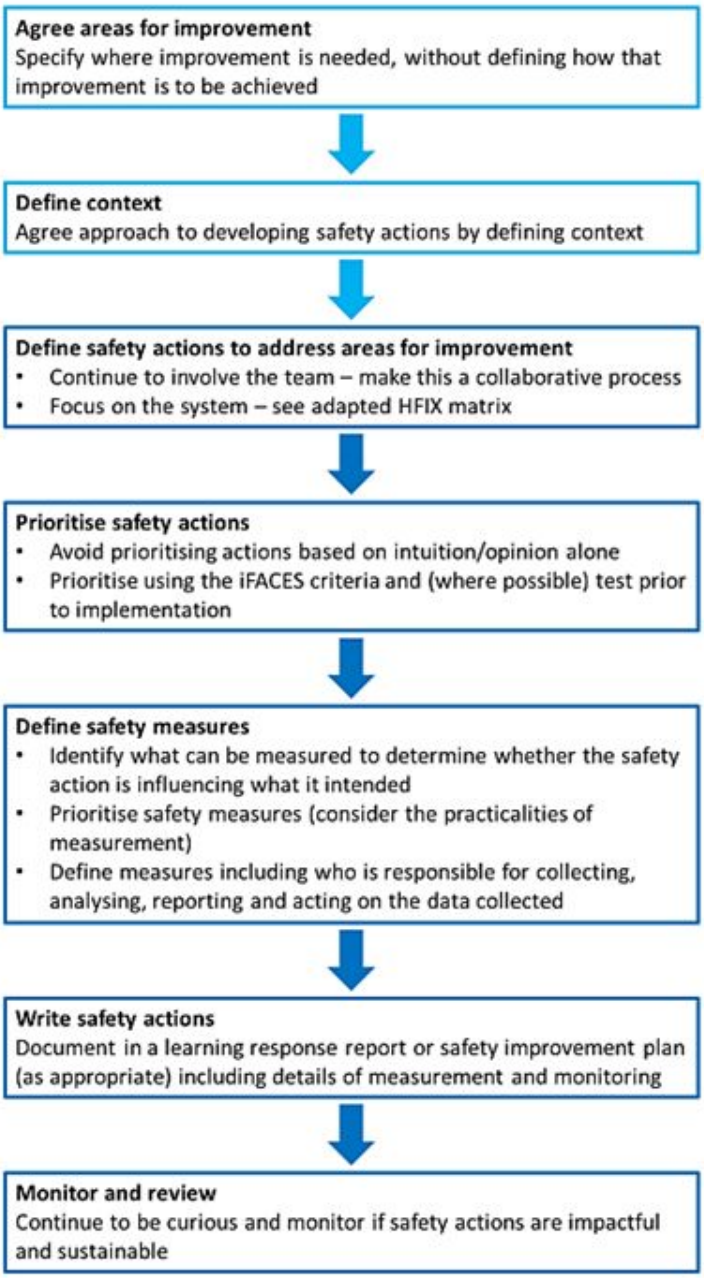
safety actions are needed. These actions need to be delivered through demonstrating high ranking evidence of assurance.

The Trust will have systems and processes in place across unit, service and divisional structures that support the design, implementation and monitoring of safety actions using an integrated approach to reduce risk and limit the potential for future harm.

Learning responses should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on identified factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from key stakeholders eg estates, IPC, safeguarding, digital, therapy teams, porters etc.

Safety Action development: The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1.


Agree areas for improvement
Specify where improvement is needed, without defining how that improvement is to be achieved
Define context
Agree approach to developing safety actions by defining context
Define safety actions to address areas for improvement
• Continue to involve the team – make this a collaborative process
• Focus on the system – see adapted HFIX matrix
Prioritise safety actions
• Avoid prioritising actions based on intuition/opinion alone
• Prioritise using the iFACES criteria and (where possible) test prior to implementation
Define safety measures
• Identify what can be measured to determine whether the safety action is influencing what it intended
• Prioritise safety measures (consider the practicalities of measurement)
• Define measures including who is responsible for collecting, analysing, reporting and acting on the data collected
Write safety actions
Document in a learning response report or safety improvement plan (as appropriate) including details of measurement and monitoring
Monitor and review
Continue to be curious and monitor if safety actions are impactful and sustainable

Agree areas for improvement – specify where improvement is needed, without defining solutions

2. Define the context – this will allow agreement on the approach to be taken for safety action development

3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams involved

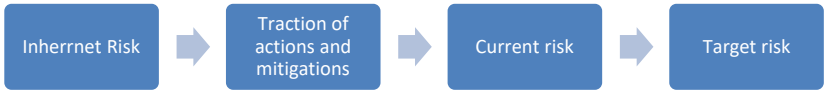
4. Prioritise safety actions to decide on testing for implementation

5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

6. Safety actions will be clearly written and follow 'Specific, Learning-Oriented, Impactful, and Measurable' (SLIM) principles and must have a designated owner.

Safety Action Monitoring

Safety actions must continue to be monitored within the Divisional SIRP governance arrangements to ensure that any actions put in place remain impactful and sustainable. This monitoring and traction of actions shall be done in alignment with a divisional safety improvement audit plan, and ongoing dynamic assessment of risk within the system, tracking mitigations and progress of risk trend.



Safety actions will be motored through unit, service and divisional governance structures learning and improving forums. The Trust safety incident response panel shall provide oversight and support to identified escalations.

ENHT Patient Safety Incident Response Framework: Improvement response pathway

PSIRF Improvement priorities shall be identified and published through the Trust annually.

Ongoing development of PSIRF improvement priorities shall be in response to continuous review of output from learning responses of single incidents, have

demonstrated sufficient understanding of the underlying interlinked system issues, ongoing dynamic risk management, and recognition of where a structured improvement response is required.

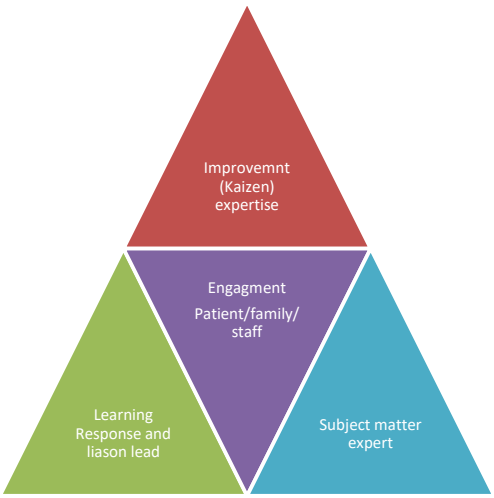
PSIRF Improvement priorities will also deliver a blend of individual safety improvement plans that focus on a specific service, pathway or locations.

PSIRF Improvement priorities shall be agreed through SIRP.

PSIRF Improvement priorities shall be cohesive, structured and formed from thematic analysis and stratification of intelligence outputs from continuous learning responses (SEIPS analysis).

PSIRF Improvement Plan shall adopt the trust single model for improvement design through ENHT Quality Management System (QMS), focusing the whole organisation on working together to enhance value from the perspective of the patient, improve quality and safety of service delivery, and embed a sustainable culture of continuous improvement.

PSIRF Improvement priorities will be addressed through combining subject matter experts, Improvement (Kaizen) trained expertise and patient/family members.



Reporting and recording of PSIRF improvements will be driven by the studying of ‘where work is done’, setting ‘SLIM’ objectives, clarity of expected benefits, share expected resource requirements, explain expected risks and associated measures for improvement, and follow standardised ENHT QMS agreed reporting templates.

The Patient Safety Incident Learning and Liaison Response structures are accountable for coordinating and delivering PSIRF Improvement priorities; and report through the Kaizen Promotion Office (KPO) governance structures.

ENHT Quality Management System: Improvement methodology:

Through the implementation of a new 'Quality Management System' a lean-based thinking and philosophy shall support improvement delivery through standardised programmes and processes, 'kaizen' aims to eliminate waste. Kaizen is a Japanese concept that means 'change for better' though in English is typically interpreted as continuous improvement. This methodology builds on a deep understanding and studying at point of care/ or where work is done.

An improvement structure KPO will oversee three categories:

- Training and education –training offers to all levels across the organisation ensuring all staff are equipped with the required knowledge and skills to integrate continuous improvement techniques into everyday working practice.
- Rapid Process Improvement Events - a range of tools and techniques will facilitate multi-day kaizen events and rapid process improvement workshops (RPIW's) involving diverse Trust teams engaged in improvement activity.
- Bespoke kaizen/improvement support – Trust staff will be able to access expert guidance and support before embarking on local improvement initiatives through a range of clinic or 'drop-in' offers.

Oversight roles and responsibilities

System oversight

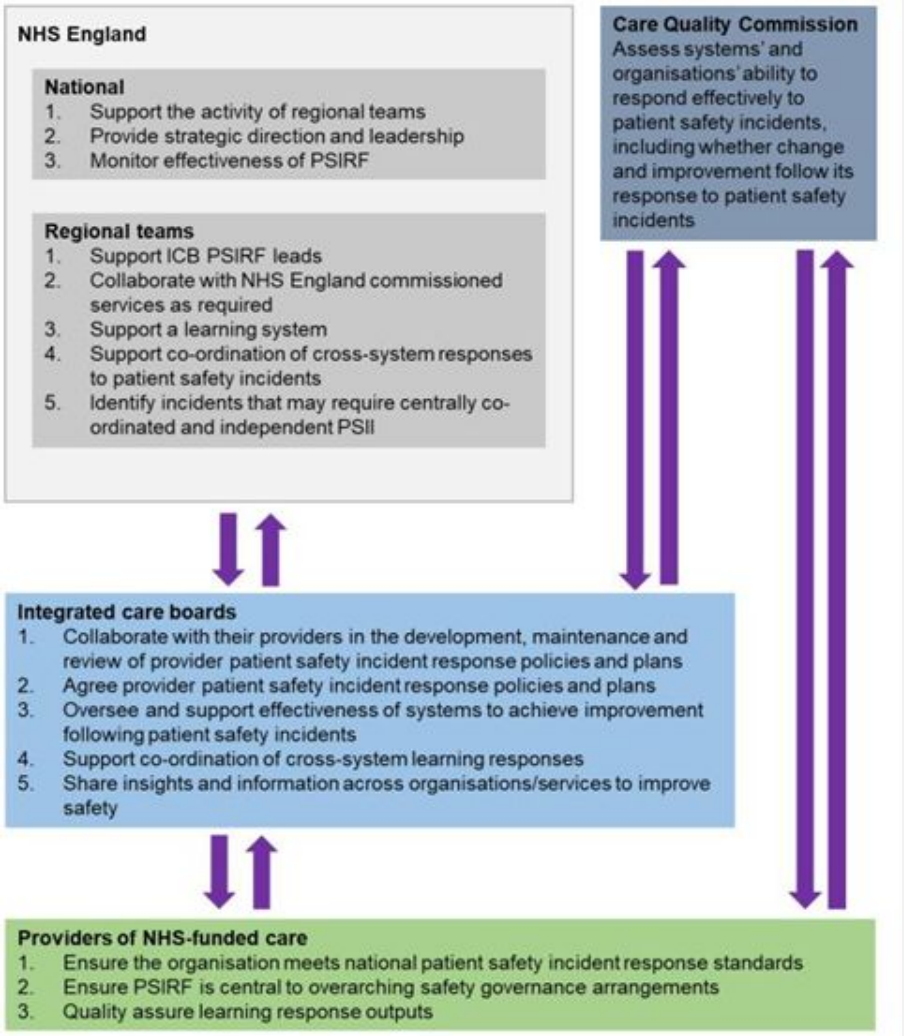
ENHT will continue to partner with ICB, regional and national networks to facilitate delivery of PSIRF Safety Standards.

This will be done through collaborative parentship working with systems partners and wider healthcare providers where value can be gained to support learning and improving following incidents.

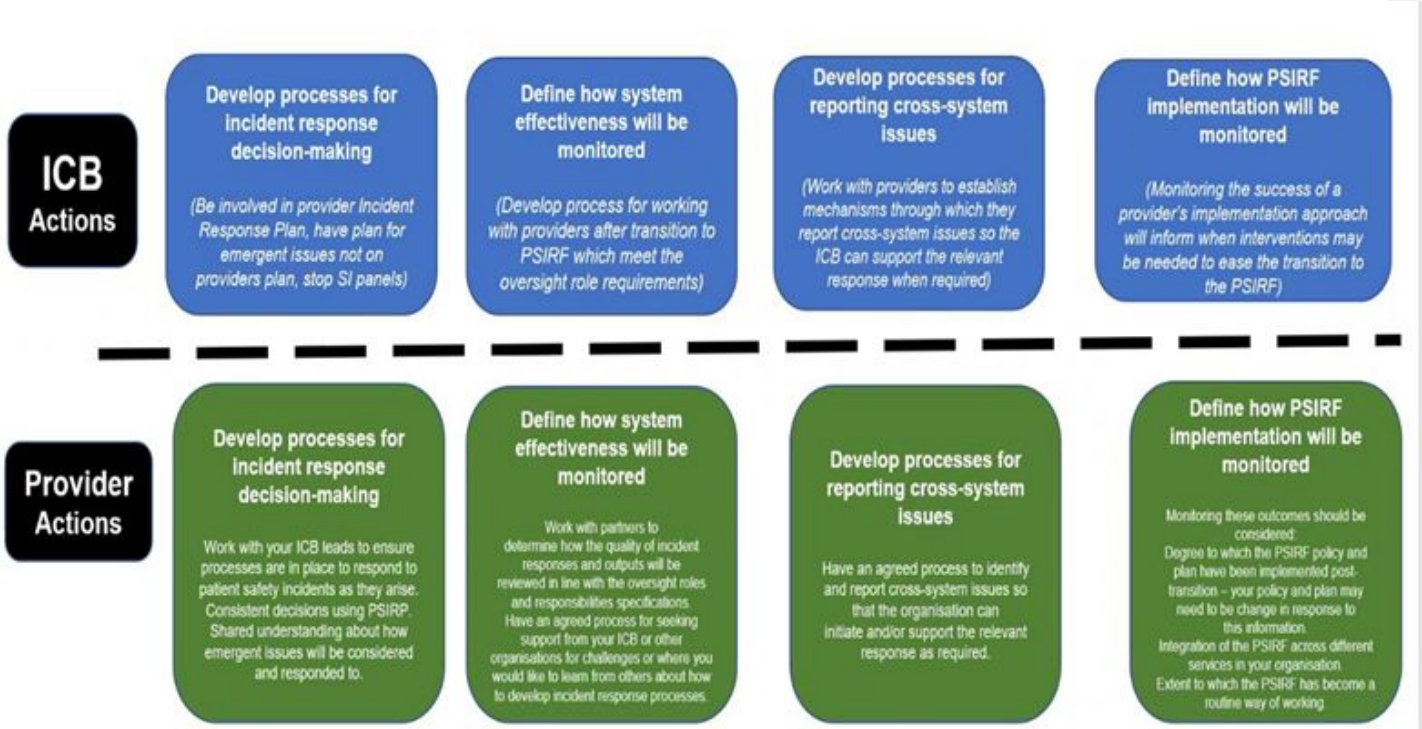
ENHT shall adopt a PSRIF mindset with partners that remains:

- Improvement focused – proposing where applicable to host system wide learning collaborative from ENHT.

- A ‘just’ and open mindset – sharing learning from errors and good practice and sharing compliance with DOC and actions taken from learning responses delivered.
- Curious and learning – proactively seek learning with system partners and support other partners to learn from ENHT, supporting system wide learning events and structures where able eg systems approach to AAR capabilities
- We shall collaborate and share information with relevant stakeholders, including the ICB, CQC through existing regulatory partnership forums, and through PLACE, ICB, Regional and national quality and transformation structures, including local networks e.g. patient safety improvement networks, patient safety specialist networks, local maternity, and neonatal systems.


NHS England
National
1. Support the activity of regional teams
2. Provide strategic direction and leadership
3. Monitor effectiveness of PSIRF
Regional teams
1. Support ICB PSIRF leads
2. Collaborate with NHS England commissioned services as required
3. Support a learning system
4. Support co-ordination of cross-system responses to patient safety incidents
5. Identify incidents that may require centrally co-ordinated and independent PSII
Care Quality Commission
Assess systems' and organisations' ability to respond effectively to patient safety incidents, including whether change and improvement follow its response to patient safety incidents
Integrated care boards
1. Collaborate with their providers in the development, maintenance and review of provider patient safety incident response policies and plans
2. Agree provider patient safety incident response policies and plans
3. Oversee and support effectiveness of systems to achieve improvement following patient safety incidents
4. Support co-ordination of cross-system learning responses
5. Share insights and information across organisations/services to improve safety
Providers of NHS-funded care
1. Ensure the organisation meets national patient safety incident response standards
2. Ensure PSIRF is central to overarching safety governance arrangements
3. Quality assure learning response outputs

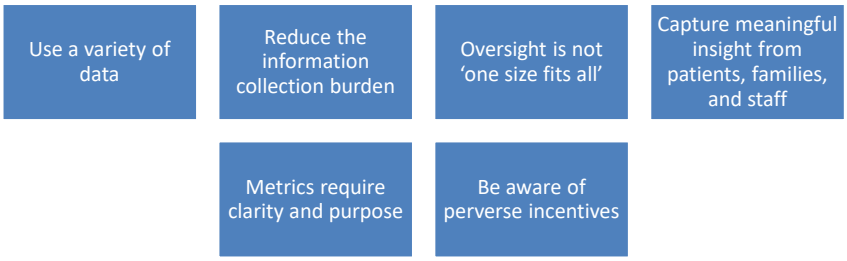
Development of standard operational plans will include:



ENHT Oversight

The PSIRF governance structure will be core to the wider Quality Management System, across key drivers of learning and improving and seeking compliance and assurance of PSIRF Safety Standards.

Standard Operational Procedures shall be set to enable the reporting mechanician and oversight through DSIRP and SIRP governance structure through core principles:



Dependencies

- Trust Quality Accounts and Quality Contract agreement
- Trust audit programmes, particularly key NICE guidelines pertaining to safety priorities and Nursing fundamentals, Pathways to Excellence Accreditation programme
- Commissioning for quality programmes (CQUIN)
- patient experience surveys
- staff experience surveys
- postgraduate training
- PLACE based improvement priorities
- Trust objectives
- internal performance reviews

Key Stakeholders

- ENHT patients, parents, carers and residents
- Patient safety partners (PSPs)

- ENHT staff: specifically including Divisional Directors, Senior management, Clinical Directors forum, Matrons forum, Consultants.
- local GPs
- local acute, specialist, mental health and community provider organisations
- EAST Ambulance Service
- local patient, public and voluntary groups
- ICB and special commissioning groups
- NHS England
- NHSR
- local and national Patient Safety Speciality networks

Performance Measures and Success Criteria

- Quantitative and qualitative data described below will be collected retrospectively from year 2022/2023 (or before where possible) and measured from year 2023/24 onwards:
    - Hospital standardised mortality rate (HSMR)
    - cardiac arrest rate
    - unexpected admission to critical care rate
    - never event prevalence
    - reporting of zero-harm or near-miss incidents (should increase)
    - reporting of moderate and significant harm incidents (should decrease)
    - improved staff survey results in relation to patient safety culture
    - patient safety culture survey
    - patient experience survey results
    - number of improvement initiatives with tangible patient co-design.

Complaints and appeals

On occasion it is recognised by East and North Hertfordshire Trust that patients, families and carers will be dissatisfied with aspects of the care and services that have been provided by the Trust. A fair, sensitive and accurate response to patient, families and carers complaints is one of the ways of improving the quality of care within the Trust. We strive to create an environment and culture in which patients know it is acceptable to raise a complaint or concern or offer feedback about our services.

It is essential for all to understand that complaints and concerns are two separate processes and not all concerns would be escalated to a complaint. The Trust is committed to responding promptly to all concerns and complaints in an open, honest

and sensitive way; ensuring that they are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner.

The Patient Advise and Liaison Service (PALS) would be the first point of contact and can support the resolution of concerns. PALS aim to provide a fast and appropriate access to help, advice and information to those users of our services who require assistance or support. It may also be more appropriate to deal with and resolve in a more immediate and timely manner as long as this is with the agreement of the person raising the concern.

A formal complaint requires an in-depth, formal investigation and response due to complexity or nature of content, by a person independent to the immediate service. Patients, carers and their representatives experience of our services can be from a different perspective and can provide a valuable insight and enable the Trust to implement changes from lessons learnt as part of the organisation's commitment to continuous quality improvement.

We will endeavour to ensure that:

- there is a culture of openness and transparency, that information and processes are accessible and understood by all those involved in a complaint
- complaints are managed and investigated with a consistent approach
- complaints are investigated and responded to sympathetically and in an appropriate negotiated timeframe
- responses should provide a level of detail relative to the seriousness of the complaint
- complainants are provided with support and guidance throughout the complaints process
- the care of a patient is not negatively impacted on as a result of a complaint
- matters are put right wherever possible, and an apology offered
- there is learning from complaints resulting in better practice

The Trust is strongly committed to the organisational learning, and recognises that whatever the circumstances, and however regrettable these may be, each complaint provides opportunities for organisational learning to occur. Sometimes, the complaint has Trust wide, or cross service implications. The learning for such complaints will be ensured by Quality and Safety Committee and Patient and Carer Experience Group.

The Trust policy for [Managing complaints and concerns CP 306] can be found on the intranet.

Part 3 – Appendices

None

Part 4 - Document record

As per policy **CP 116 Trust policies and procedural documents**, this document is using the latest format of **Template for Trust-approved documents TMP 001 (Version 2)**.

Document info	Doc ID: CP 310, Version – 001 Patient Safety Incident Response Framework This version is using TMP 001 – 01 April 2023
Document type	Select one option: ☐ Guideline, ☐ Pathway, ☒ Policy,☐ Procedure, ☐ Protocol, ☐ Standard Operating Procedure **Policy**
Document applicability across the organisation	SELECT ONE for each of the 3 items 1. **For use** ☒Trust wide (at corporate level for both clinical and non-clinical roles); ☐ clinical cross specialty; ☐ in multiple areas (non-clinical); ☐ locally 2. **For use by** (ROLES): ☒All roles, ☐clinical roles only, ☐ non-clinical roles only 3. **For use at** (SITES): ☒All sites,☐ Lister Hospital, ☐New QEII, ☐Hertford County Hospital, ☐Renal Satellite sites, ☐Mount Vernon Cancer Centre, ☐Other: **Input your selection here:** **For use Trust wide by all roles at all sites**
Review cycle	☐ Every 3 years (standard) ☒Annual review ☐ Other: **01 October 2024**
Version type	SELECT ONE ☒New document – full consultation and endorsements ☐Full review of document - various amendments/ complete re-write ☐Full review of document - minor amendments ☐Full review of document - no changes to content, still fit for use ☐Interim update - document not fully reviewed, amendments only **New document – full consultation and endorsements** Select the appropriate sign-off category ☒TYPE A (full review requires both endorsement and approval) ☐TYPE B (interim update – only approval required) ☐TYPE C (local use): Both endorsement and approver required **Type A – endorsements and approval**
Keywords	

Version author/owner	Director of Quality ☐Cancer ☐Planned ☐Unplanned ☐Women & Children ☒Corporate/Directorate
Document classifications	Please select all that apply to this document ☐ **Sensitive information**: This document contains sensitive information that should not be shared outside the organisation ☐ **Public website**: this document has been selected for publication on the Trust website, maintained by the Communications Dept. ☐ **Patient Consent**: This document contains content about patient consent ☐ **Forms** - This document contains forms in use at the Trust ☒ None of the above

Consultation & review

In the checklist below, the document author has considered the following **resource implications** and **impact to Trust-wide functions/services**, which also require **oversight** of local processes. Any of these listed stakeholders may also be an endorser of the final version of this document in the Record of agreement section.

If a new document, or newly amended content to this version contains processes that will have an impact on Trust functions and their users, the following actions are required.

Trust stakeholder	Action required by author
1. **Equality, Diversity & inclusion**	Trust **policies** require an Equality Impact Assessment (EIA) as evidence that the protected characteristics under Equality Act 2010 have been considered, as per Part 1, section 6.1 in this document. If the initial EIA screening in Part 1, section 6.1 determines a full EIA is required, visit the Equality, Diversity & Inclusion intranet section for next steps, which could take **3 to 4 weeks to receive approval.** EIA approval (supplied via email): Click or tap to enter a date.
2. **Clinical Ethics Committee**	This document may contain content that is contentious or raises moral debate. ☐No – proceed to next item ☐Yes – please see following actions

Trust stakeholder	Action required by author
	Step 1: Seek advice from Clinical Ethics committee: ethics.enh-tr@nhs.net **Step 2**: Please provide the following info: Date of recommendations received: Were recommendations implemented and/or incorporated into document? ☐yes ☐no What was recommendation:
3. Medicines Management (Pharmacy)	This document contains processes about the use of medicines at the Trust. ☐No – proceed to next item ☐Yes – please follow these steps **Step 1**: Contact local pharmacy lead to coordinate presentation to Therapeutics Policy Committee to request their **endorsement (formal agreement the document is fit for use at the Trust)** **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: TPC requires sign off on the final file and will be the final approver in the Record of agreement.
4. Nursing, Midwifery & AHP	This document contains processes that will have an impact on staff and care or that would affect work routines. ☐No – proceed to next item ☐Yes – please see following steps **Step 1:** For documents that are for Trust-wide use, **contact Nursing & Midwifery Excellence team** to discuss who would need to be involved in reviewing and agreeing the document is fit for use at the Trust. ☐Clinical skills group and/or ☐Nursing, Midwifery, AHP Quality Committee and/or ☐The appropriate training team eg Nursing/Maternity Training Team (For documents for local use, contact in the first instance). ☐Other: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**

Trust stakeholder	Action required by author
	Step 3: If stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
5. Safeguarding	This document (either for local or Trust-wide use) contains processes or information that may have an impact on children or vulnerable adults using our services. ☐No – proceed to next item ☐Yes **Step 1**: Contact **Safeguarding** team for initial discussion. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**
6. People (Human resources)	This document (either for local or Trust-wide use) contains processes or information about the recruitment or management of staff or other processes applicable to staff. ☐No – proceed to next item ☐Yes **Step 1**: Contact Trust Partnership committee, staff side and/or staff network groups for initial discussions. **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: In most cases, for these Trust-wide documents owned by the People team, the **Trust Partnership** requires sign off on the final file and should be the **approver** in the Record of agreement.
7. Finance	This document contains processes or information that affects the acquisition of resources (recurring or one-off) or payments of salaries or anything that has financial implications either Trust wide or locally within the Trust. ☐No – proceed to next item ☐Yes – please follow steps **Step 1**: Involve/request input from: ☐payroll, ☐local budget holders, ☐anti-fraud team Name of contact: **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders**

Trust stakeholder	Action required by author
	Step 3: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
8. Estates & Facilities	This document contains processes or information about the use of Trust property or affects facilities and security on Trust premises. ☐No – proceed to next item ☐Yes **Step 1**: Involve/request input from ☐Estates ☐Facilities **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
9. Digital (IT)	This document contains processes or information about the use of Trust computer hardware, software or systems. This includes systems either managed by our local Digital team or an external supplier. ☐No – proceed to next item ☐Yes **Step 1**: Involve/request input from the appropriate team in Digital services **Step 2**: Record consultation activity in item 10 in this list: **Other areas or stakeholders** **Step 3**: If the stakeholder requires sign off on final file, they can be an endorser in the Record of agreement.
10. Senior division/ directorate staff	Document owner must apprise senior staff in their relevant area of this new or fully reviewed document. **Step 1** **Divisions (clinical areas)**: Apprise **divisional clinical governance group** of document development or send final draft for the formal meeting record and so respective the clinical director is apprised at that meeting. **Directorate (corporate/ non-clinical areas)**: Advise respective senior level group meeting of updated document so this activity is on the formal record.

Trust stakeholder	Action required by author
	Step 2 In item 11 below, record date and name of clinical governance meeting/ senior level group meeting as a stakeholder (select external). Select the activity type as "other" and indicate "for information only".
11. Document stakeholders	In the table below, please record evidence (ie date of meetings or email) of activity with departments, groups, stakeholders involved in the update/development of this document. A minimum of one stakeholder must be listed. Please delete unused rows.

11.1 List of document stakeholders

Document stakeholder	Date	Activity type
Michelle Anstiss, Interim Associate Director of Governance ☒**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Dr Jon Bramall, Associate Medical Director Patient Safety specialist ☒**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Lucinda Berry, Legal and governance lead ☒**Internal*** ☐**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☒Content contribution ☐Read and agree fit for use ☐Other:
Chris Curtis, patient safety partner ☐**Internal*** ☒**External****	DD-MM-YYYY ☐Meeting date ☐Email date	☐Content contribution ☒Read and agree fit for use ☐Other:

***Internal** – a stakeholder within document author's dept/service/area – a service manager, team meeting, etc.
****External** - a stakeholder outside of dept/service/area or outside the organisation

☐At least one of the above in the consultation list is a formal endorser in the Record of agreement.

☐I understand an endorser and/or approver may request evidence of consultation (with any of the above or others not mentioned) before their sign off is granted.

Other consultation and stakeholder actions required

Not applicable.

Record of agreement

Full details of the **endorsement and approval process** can be found in policy **CP 116 - Trust policies and procedural documents**.

DOC ID & title	CP 310, Version: 001 - Patient Safety Incident Response Framework
Due date of next full review	01 October 2024
Document type	Policy
Version type	New document – full consultation and endorsements
Applicability	For use Trust wide by all roles at all sites
Version author	Director of Quality
Sign-off type	Type A – endorsements and approval

Trust endorsement for all policies	Record of formal agreement this version is fit for use at the Trust by **Policy Compliance Group** under action log item [**insert reference number**] at meeting held on **YYYY-MM-DD**.
Approval	Upon considering the above endorsements, the approver* [Insert name of approver, as identified in formal sign-off process for doc owner's area] agrees this document is fit for use at the Trust. Confirmation of this agreement (delete as appropriate) is supplied in email dated **YYYY-MM-DD /** is in meeting minutes/ meeting action log under item [**insert reference number**], held on **YYYY-MM-DD**.
Governance checks	ADMIN USE ONLY

*Types of **approvers** (as per policy CP 116):

- A committee/group or Trust function stakeholder's name, role, dept can approve a **fully reviewed** document
- A head of service, or stakeholder or committee chairperson (usually endorser 1 listed at the last full review) can approve an **interim update** of a document
- A head of service or department can approve documents for **local use only** (for all version types)
- All policies require "additional endorsement" from the Policy Compliance Group.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	13
Report title	Summary Learning from Deaths Report			**Meeting Date**	6 September 2023
Presenter	Justin Daniels, Medical Director				
Author	Sarah Sharnoubi, Mortality Improvement Lead				
Responsible Director	Mark Hearn, Associate Medical Director for Reducing Unwarranted Variation			**Approval Date**	14 June 2023
Purpose *(tick one box only)* [See note 8]	**To Note**	☐	**Approval**		☐
	Discussion	☒	**Decision**		☐

Report Summary:

Reducing mortality remains one of the Trust's key objectives. This quarterly report summarises the results of mortality improvement work, including the regular monitoring of mortality rates, together with outputs from our learning from deaths work that are continual on-going processes throughout the Trust.

It also incorporates information and data mandated under the National Learning from Deaths Programme.

Impact: where significant implication(s) need highlighting

Significant impact examples: Financial or resourcing; Equality; Patient & clinical/staff engagement; Legal
Important in delivering Trust strategic objectives: Quality; People; Pathways; Ease of Use; Sustainability
CQC domains: Safe; Caring; Well-led; Effective; Responsive; Use of resources

1. **Trust Strategic Objectives:**

Quality: Consistently deliver quality standards, targeting health inequalities and involving patients in their care

Thriving people: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability

Seamless services: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners

Continuous improvement: Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

2. **Compliance with Learning from Deaths National Quality Board (NQB) Guidance**
3. **Potential impact in all five Care Quality Commission (CQC) domains**

Risk: *Please specify any links to the BAF or Risk Register*

Please refer to page 6 of the report

Report previously considered by & date(s):

Mortality Surveillance Committee – 14 June 2023
Quality & Safety Committee – 28 June 2023

Recommendation	The Board is invited to note the contents of this Report.

To be trusted to provide consistently outstanding care and exemplary service

This report provides a summary of the information contained in the detailed Learning from Deaths report which has been considered both by the Mortality Surveillance Committee and the Quality and Safety Committee. This summary is provided to the public Board meeting in line with NQB Learning from Deaths national reporting requirements.

Following the deeply shocking revelations of the Letby case we have included a comment from the Medical Director in this report. It is attached as Appendix 1.

1. Headline mortality metrics

Table 1 below provides headline information on the Trust's current mortality performance.

Table 1: Key mortality metrics

Metric	Headline detail
Crude mortality	Crude mortality is 1.18% for the 12-month period to April 2023 compared to 1.29% for the latest 3 years.
HSMR: (data period Mar22 – Feb23)	HSMR for the 12-month period is **96.17, 'Mid-range'.**
SHMI: (data period Jan22 – Dec22)	Headline SHMI for the 12-month period is **90.74, 'as expected' band 2.**
HSMR – Peer comparison	ENHT ranked 4th (of 11) within the Model Hospital list* of peers.

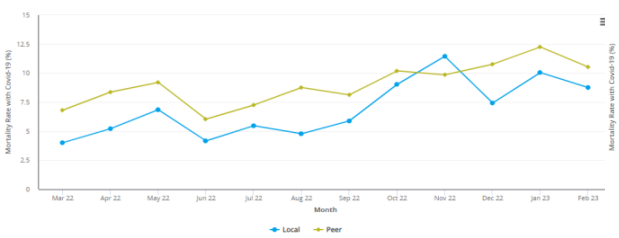
* We are comparing our performance against the peer group indicated for ENHT in the Model Hospital (updated in 2022), rather than the purely geographical regional group we used to use. Further detail is provided in 2.2.3.

2. COVID-19

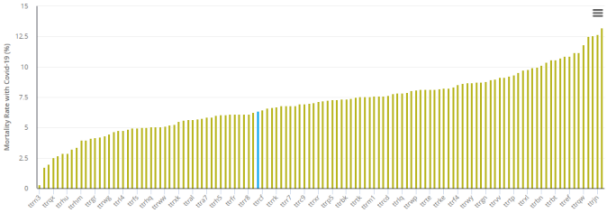
The following charts provided by CHKS show how the Trust's mortality rate for Covid compares with our national peers.

Fig 1: Covid-19 Peer Comparison: March 2022 to February 2023

Mortality Rate with Covid-19 (Peer: National)



Mortality Rate with Covid-19 National peer comparison



3. Mortality alerts

3.1 Rolling 12-month 3 standard deviation outlier CUSUM alerts

The latest release from CHKS showed two HSMR CUSUM red alerts which constituted a rolling 12-month 3 standard deviation outlier, for the year to February 2023. A coding review of Leukaemia previously agreed, did not reveal coding errors or indicate clinical concerns. A coding and clinical review of AMI had already been requested. Initial findings were reported to March Mortality Surveillance Committee. It identified that 24 of the 53 deaths reviewed had been incorrectly coded for a variety of reasons including coding error, poor documentation resulting in the data not providing a true reflection of AMI clinical activity. It was agreed the Head of Coding and the Clinical Director of Cardiology should undertake further investigation of the issues identified to clarify what further improvement actions are required. An update is scheduled for July.

Table 2: HSMR CUSUM Alerts March 2022 to February 2023

Relative Risk	Observed Deaths	Expected Deaths	"Excess" Deaths

100 - Acute myocardial infarction	162.50	57	35	22
39 - Leukemias	214.10	18	8	10

Source: CHKS (CUSUM alerts coloured)

The CHKS report also indicated three SHMI CUSUM red alerts for the period to November 2022 which constituted rolling 12-month 3 standard deviation outliers, as detailed in the table below. As detailed above a coding review of Leukaemia deaths had not given rise to concerns. Coding reviews of the remaining two diagnosis groups did identify significant numbers of patients being admitted with pressure sores and tissue infections. It was agreed that the data and findings should be shared with the Adult Safeguarding team.

Table 3: SHMI Outlier Alerts December 2021 to November 2022

	SHMI	Observed Deaths	Expected Deaths	"Excess" Deaths
107 - 197: Skin and subcutaneous tissue infections	224.91	31	14	17
27 - 39: Leukemias	254.76	19	7	12
109 - 201: Infective arthritis and osteomyelitis (excluding TB/STD)	253.89	10	4	6

3.2 External alerts

3.2.1 National Hip Fracture Database (NHFD) mortality alert (August 2019)

As previously reported, in June 2021 we received notification from the NHFD that in the forthcoming annual report we would be showing as a 3 standard deviation outlier.

At its worst point, for the period to January 2021, 30-day mortality stood at 13.5%, significantly above the national average of 8.7%. The latest data to February 2023 has shown a continuation of our improving performance with mortality standing at 5.0%, compared to a national figure of 5.3%. This was the second consecutive month where performance was better than the national average.

At February Mortality Surveillance Committee, it was agreed that the current work had progressed as far as it could, with the outstanding action regarding theatre capacity being integrated into a wider workstream. The Mortality Improvement Lead agreed to work with the #NOF Lead to update the original interim report to final.

3.2.2 Ovarian Cancer Audit on 30 Day Mortality for Systemic Anti-Cancer Therapy (SACT)

In April 2022 a presentation was given by the MVCC Oncology service at Mortality Surveillance Committee regarding the findings of the Ovarian Cancer Audit on 30 Day Mortality for Systemic Anti-Cancer Therapy (SACT), as the 2017-21 audit had identified the Trust as an outlier.

While the presentation gave a compelling argument for the treatment approach adopted by the MVCC cancer service for ovarian cancer, and how this potentially underlay the mortality alert, it was agreed that being such a specialist area, an external review was required in order to provide independent assurance to the Board. In August 2022 contact was made with The Christie specialist cancer trust, who agreed to undertake the peer review.

Initial findings have now been shared with the Trust. On the back of these the Medical Director has asked the service to develop a suite of recommendations to address the issues and concerns raised.

4. Focus areas for improvement/monitoring

Table 4: Focus Areas for Improvement

Diagnosis group	Summary update
Cardiology diagnoses	As a result of the continuing deterioration in the Trust's HSMR for acute myocardial infarction, in February the Mortality Surveillance Committee requested the service to undertake an immediate review of the situation. In March initial findings showed that approximately 50% of the deaths had been incorrectly coded due to multiple factors meaning the data was not a true reflection of AMI clinical activity. Further work was agreed with an update scheduled for July.
Sepsis	HSMR performance relative to national peer remains well placed. There has been some improvement regarding achievement of sepsis targets, but this continues to be variable.
Stroke	Latest SSNAP rating remains D. April 2022 to January 2023 has seen HSMR and SHMI steadily increasing. The Stroke service is to be asked to provide a report on their understanding of the situation at September Mortality Surveillance Committee. Following the national set up of Integrated Stroke Delivery Networks (ISDNs), collaborative work via the East of England South network continues.
Emergency Laparotomy	Focussed improvement work remains on-going. This has included the setting up of a working group to support the service. A NELA data coordinator is now in post and focussed on clearing the backlog of cases. It is recognised that correct case ascertainment is extremely important. In this regard strengthening the multi-disciplinary approach, especially for high-risk patients will remain a focus for the improvement work. Ongoing challenges include the current lack of a dedicated Emergency Theatre for general surgery and the ongoing delay to the re-establishment of the Surgical Assessment Unit.

5. Learning from deaths data

5.1 Mandated mortality information

The Learning from Deaths framework states that trusts must collect and publish certain key data and information regarding deaths in their care via a quarterly public board paper. This mandated information is provided below for Q4 2022-23.

Table 5: Q4 2022-23: Learning from deaths data

	Jan-23	Feb-23	Mar-23
Total in-patient deaths	146	110	140
Deaths with SJR completed to date (at 11.05.23)	31	23	16
SJRs resulting in Datix incident report (by month of death)	9	3	3
Concluded ACONs (2022-23 deaths): possibly avoidable (≥50%) due to problem in care (by month of conclusion)	0	0	1
Learning disability deaths	2	3	0
Mental illness deaths	1	1	4
Stillbirths	0	1	1
Child deaths (including neonats/CED)	0	0	0
Maternity deaths	0	0	0
SIs declared regarding deceased patient	2	0	1
SIs approved regarding deceased patient	1	1	0
Complaints regarding deceased patient	6	2	4
Requests for a Report to the Coroner	22	7	7
Regulation 28 (Prevention of Future Deaths)	0	0	0

5.2 Learning from deaths dashboard and outcomes summary

The National Quality Board provided a suggested dashboard for the reporting of core mandated information. This dashboard has previously been provided in this report. However, the current transition from our old in-house mortality review tool to using the SJR*Plus* tool and approach, part way through the 2022-23 reporting year presents a reporting challenge, as the data aligns differently. In the short term, while the transition is made, the dashboard will not be used. It is proposed that from Q1 2023-24 either it, or an alternative contextual dashboard created by the NHSE Making Data Counts team, will be reintroduced.

5.2.1 Concluded Areas of Concern (ACON)
In the meantime, until all ACONs raised up to 30 June 2022 are completed, both ACONs – with their outcomes, and new patient safety escalations with theirs, will be reported. Every effort is being made to close legacy ACONs as quickly as possible. In the longer term, the new SJR process will make reporting easier, as the preventability of death is indicated by the reviewer at the point of the initial review, not on completion of the ACON process, which will reduce the current time lag.

It should be noted that for cases where Areas of Concern (ACONs) have been raised, the current lapse in time between the death and completion of the review process means that the avoidability of death score may not be decided in the same review year. Therefore, for the sake of transparency and robust governance this report details ACONs relating to all deaths which have been concluded during the quarter in question where the Mortality Surveillance Committee agreed an avoidability of death score of 3 or less (irrespective of the year in which the death occurred). Table 6 below details relevant cases concluded in Q4. Both the cases where it was considered there was strong evidence of avoidability have been rigorously investigated as serious incidents.

Table 6: Q4 2022-23 Concluded ACONs: Avoidability Score ≤3

ID	Year of death	Serious Incident	Avoidability score	Avoidability definition
-	-	-	1	Definitely avoidable
699 739	2021/22 2022/23	Yes Yes	2	Strong evidence of avoidability
526	2020/21	No	3	Possibly avoidable: more than 50-50

5.2.2 SJR patient safety incident escalations since 1 July 2022

For deaths in Q2/Q3/Q4 which have been subject to an SJR, 65 cases have been escalated as potential patient safety incidents. When we adopted the SJR format and revisited our internal quality and governance processes, it was agreed with our Patient Safety team, that where a reviewer indicated there was any evidence of preventability, the case should be raised as a patient safety incident, ensuring thorough review and discussion of the case at Specialty/Divisional level. As a result, new patient safety escalations do not directly correlate to prior cases raised as ACONs. They will include cases involving a lower level of concern, but which still provide valuable opportunities to learn.

Table 7: Q2/Q3/Q4 Patient Safety Incidents reported following SJR

Escalations for deaths in month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Patient Safety incident scalations from SJRs	12	8	5	11	8	6	9	3	3	65

Learning from concluded patient safety investigations will be collated and added to themes and trends identified in SJRs to inform future quality and improvement work.

6. Learning and themes from concluded mortality reviews

Historically, throughout the year emerging themes have been collated and shared across the Trust via governance and performance sessions and specialist working groups. The information has also been used to inform broad quality improvement initiatives. With the advent of a new approach to mortality review, the ways in which learning is shared and the methods for assessing its impact are being revisited.

7. Current risks

Table 8 below summarises key risks identified:

Table 8: Current risks

Risks	Red/amber rating
Cardiology: recurrent HSMR and SHMI alerts (especially AMI)	
Ovarian Cancer SACT 30 Day Mortality: External review findings	
Medical Examiner Integration & Community expansion	
Mortality review reform: Using the new review tool for reporting & learning	
Use of the new ENHance: system for escalation, reporting and learning and sharing	

8. Options/recommendations

The Board is invited to note the contents of this Report.

Appendix 1

An addendum to the Learning from Deaths Report following the Letby court case

Lucy Letby has recently been found guilty of killing babies on the neonatal unit at The Countess of Chester Hospital. Our first thought must be with the bereaved families and those caring for children harmed by her.

Following this tragic event, we need to consider what processes we have in place at East and North Hertfordshire NHS Trust to help ensure that the services we provide are safe.

There are a number of important protective factors:

1. A culture of openness
2. A senior leadership team that listens to clinicians
3. Board level scrutiny of mortality data and deaths
4. Child Death Overview Panel
5. The establishment of the Medical Examiner Office
6. Introduction of Patient Safety Incident Response Framework with a focus on further improving our safety culture.

1. A culture of openness

In the last year, East and North Hertfordshire NHS Trust has appointed a full time, Freedom to speak up guardian. By chance she was previously a Neonatal Matron. Her work has led to a doubling of concerns being expressed. Additionally, our chief executive has an ‘Ask Adam’ email that empowers any member of staff to raise any matter of concern, whether clinical or non-clinical, directly with the chief executive.

2. A senior leadership team that listens to clinicians

On a daily basis members of the executive team spend time in clinical areas talking with staff. This enables them to be aware, in real time, of what is happening clinically, of pressures experienced by staff and of incidents as they occur. The Director of Nursing and Medical Director also take part in chairing the Serious Incident Review Panel and therefore have oversight of potential serious incidents within the organisation.

3. Mortality Surveillance and Learning from Deaths

The Trust works with CHKS (a leading provider of healthcare intelligence) who provide and benchmark our mortality data. This is then reviewed by our mortality team and discussed at our Mortality Surveillance Committee. Key data and analysis are then presented to both the Quality and Safety Committee and the Board. Every month CHKS provides refreshed data, including crude mortality, SHMI and HSMR, together with detail of any alerts relating to specific diagnosis groups.

A significant number of cases are also independently reviewed by a clinician who was not involved in the care of the deceased patient, using the standardised structured judgement review methodology first introduced by the Royal College of Physicians in 2016. Cases for review are selected in a number of ways including, if there is any suspicion of increased mortality in any patient group or diagnosis group, referral by the Medical Examiner, and also if any member of staff or relative feels that there was anything lacking in the care received by the patient. This assessment of care is used to identify and share learning, check for any themes or trends of concern and escalate any patient safety issues identified.

4. Child Death Overview Panel (CDOP)

CDOPs monitor all child deaths and haver been in existence since 2008. They have a statutory role in looking at the deaths of all children from the age of viability to 18. They work closely with all of the other agencies and across the county to facilitate the monitoring of, and learning from child deaths.

5. The establishment of the Medical Examiner Office

The Trust has a team of medical examiners who scrutinise all in-hospital deaths. From April 2024 they will also be responsible for the scrutiny of deaths in the community. Their primary function is to provide independent scrutiny of all deaths and they are directly responsible to the National Medical Examiner. In their work, in addition to agreeing the cause of death, they also speak with relatives to check if they have any concerns and importantly, monitor deaths to identify any themes or trends. They are in a unique position to challenge the Trust and escalate cases that they consider need further review or investigation.

6. Patient Safety Incident Response Framework (PSIRF)

Our Trust is in the initial stages of introducing a different approach to managing and learning from both patient safety incidents (PSIRF) and those related to employee relations. Our ambition is to establish a restorative, just and learning culture (RJLC) within the organisation, one that promotes no blame, psychological safety and quality improvement without jeopardising accountability.

Justin Daniels
Medical Director

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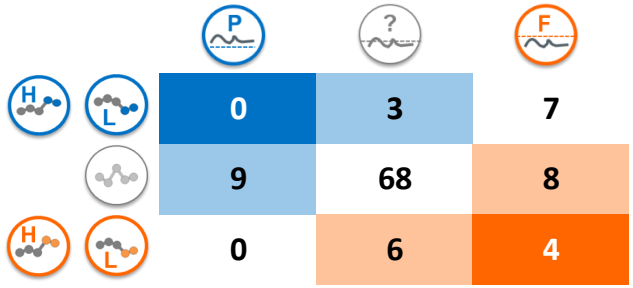
Integrated Performance Report

Month 04 | 2023-24

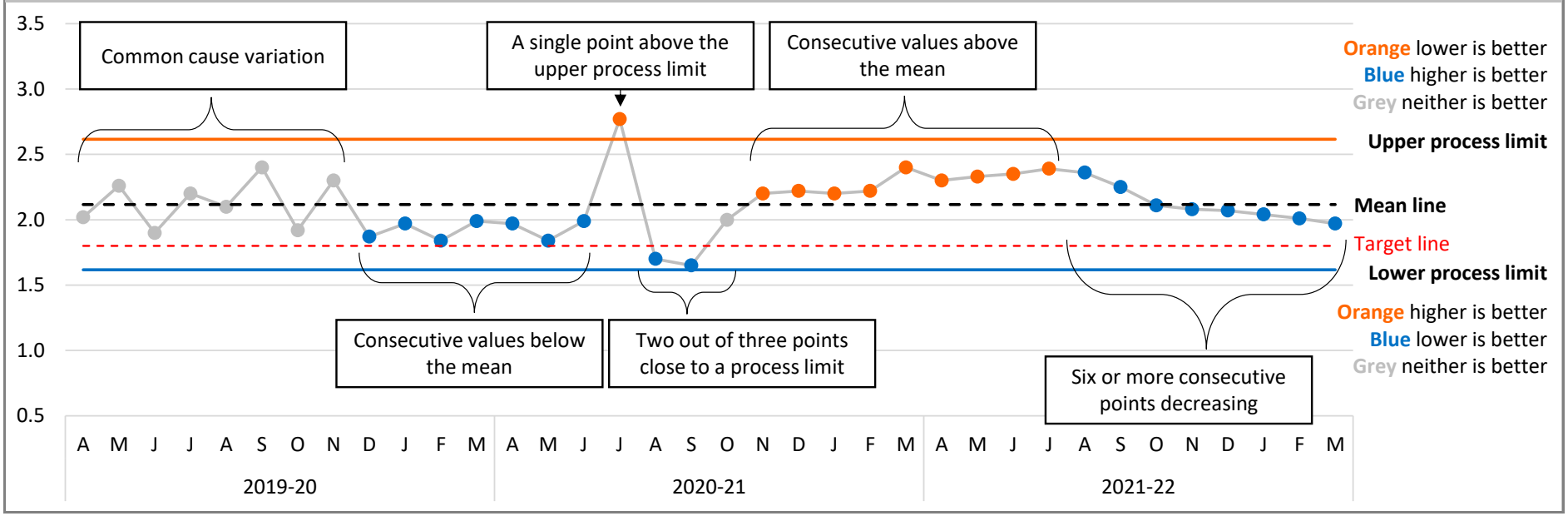


Data correct as at 24/08/2023

Integrated Performance Report

East and North Hertfordshire NHS Trust

How to interpret a Statistical Process Control (SPC) Chart



Variation

H L	Special cause variation of **concerning** nature due to **H**igher or **L**ower values
H L	Special cause variation of **improving** nature due to **H**igher or **L**ower values
	Common cause variation No significant change

Assurance

F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

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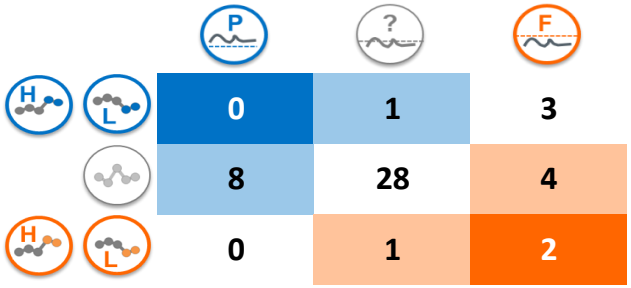
Quality

Month 04 | 2023-24



Quality

East and North Hertfordshire NHS Trust

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Safety Incidents	Total incidents reported in-month	Jul-23	n/a	1,221			Common cause variation No target
	Serious incidents in-month	Jul-23	0	6		?	Common cause variation Metric will inconsistently pass and fail the target
Infection Prevention and Control	Hospital-acquired MRSA Number of incidences in-month	Jul-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired c.difficile Number of incidences in-month	Jul-23	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired e.coli Number of incidences in-month	Jul-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired MSSA Number of incidences in-month	Jul-23	0	7		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired klebsiella Number of incidences in-month	Jul-23	0	2		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired pseudomonas aeruginosa Number of incidences in-month	Jul-23	0	0		?	Common cause variation Metric will inconsistently pass and fail the target
	Hospital-acquired CPOs Number of incidences in-month	Jul-23	0	0	L	?	11 consecutive points below the mean Metric will inconsistently pass and fail the target
	Hand hygiene audit score	Jul-23	80%	91.5%		P	Common cause variation Metric will consistently pass the target
Safer Staffing	Overall fill rate	Jul-23	n/a	78.4%			Common cause variation No target
	Staff shortage incidents	Jul-23	n/a	17			Common cause variation No target

Month 04 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cardiac Arrests	Number of cardiac arrest calls per 1,000 admissions	Jul-23	n/a	0.86			Common cause variation No target
	Number of deteriorting patient calls per 1,000 admissions	Jul-23	n/a	0.61			Common cause variation No target
Sepsis Screening and Management	Inpatients receiving IVABs within 1-hour of red flag	Jul-23	95%	100.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Inpatients Sepsis Six bundle compliance	Jul-23	95%	50.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendances receiving IVABs within 1-hour of red flag	Jul-23	95%	75.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	ED attendance Sepsis Six bundle compliance	Jul-23	95%	51.8%		F	Common cause variation Metric will consistently fail the target
VTE Risk Assessment	VTE risk assessment stage 1 completed	Jul-23	85%	76.0%		?	Common cause variation Metric will inconsistently pass and fail the target
HATs	Number of HAT RCAs in progress	Jul-23	n/a	121	H		2 points above the upper process limit No target
	Number of HAT RCAs completed	Jul-23	n/a	7			7 points below the mean No target
	HATs confirmed potentially preventable	Jul-23	n/a	5			Common cause variation No target
PU	Pressure ulcers All category ≥2	Jul-23	0	10		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Patient Falls	Rate of patient falls per 1,000 overnight stays	Jul-23	n/a	4.5			Common cause variation No target
	Proportion of patient falls resulting in serious harm	Jul-23	n/a	1.4%			Common cause variation No target
Other	National Patient Safety Alerts not completed by deadline	Jan-23	0	0			Metric unsuitable for SPC analysis
	Potential under-reporting of patient safety incidents	Feb-23	6.0%	5.8%			Metric unsuitable for SPC analysis
Friends and Family Test	Inpatients positive feedback	Jul-23	95%	96.4%		P	Common cause variation Metric will consistently pass the target
	A&E positive feedback	Jul-23	90%	96.4%		?	Common cause variation Metric will inconsistently pass and fail the target
	Maternity Antenatal positive feedback	Jul-23	93%	100.0%	H	F	7 points above the upper process limit Metric will consistently fail the target
	Maternity Birth positive feedback	Jul-23	93%	95.6%	H	F	5 points above the upper process limit Metric will consistently fail the target
	Maternity Postnatal positive feedback	Jul-23	93%	88.3%		?	Common cause variation Metric will inconsistently pass and fail the target
Friends and Family Test	Maternity Community positive feedback	Jul-23	93%	0.0%	L	F	7 points below the lower process limit Metric will consistently fail the target
	Outpatients FFT positive feedback	Jul-23	95.0%	95.8%		?	Common cause variation Metric will inconsistently pass and fail the target
PALS	Number of PALS referrals received in-month	Jul-23	n/a	300		-	Common cause variation No target

Month 04 | 2023-24

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Complaints	Number of written complaints received in-month	Jul-23	n/a	56		-	Common cause variation No target
	Number of complaints closed in-month	Jul-23	n/a	25		-	Common cause variation No target
	Proportion of complaints acknowledged within 3 working days	Jul-23	75%	100.0%		P	Common cause variation Metric will consistently pass the target
	Proportion of complaints responded to within agreed timeframe	Jul-23	80%	66.7%	L	?	Common cause variation Metric will inconsistently pass and fail the target
Maternity Safety Metrics	Caesarean section rate Total rate from Robson Groups 1, 2 and 5 combined	Jun-23	60 - 70%	69.0%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml vaginal	Jun-23	3.3%	1.3%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear vaginal	Jun-23	2.5%	1.8%		?	Common cause variation Metric will inconsistently pass and fail the target
	Massive obstetric haemorrhage >1500ml LSCS	Jun-23	4.5%	1.6%		P	Common cause variation Metric will consistenly pass the target
	3rd and 4th degree tear instrumental	Jun-23	6.3%	2.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Term admissions to NICU	Jun-23	6.0%	5.6%		?	Common cause variation Metric will inconsistently pass and fail the target
	ITU admissions	Jun-23	0.7	0		?	Common cause variation Metric will inconsistently pass and fail the target

Month 04 | 2023-24

Quality

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Maternity Other Metrics	Smoking at time of booking	Jun-23	12.5%	6.0%		P	Common cause variation Metric will consistenly pass the target
	Smoking at time of delivery	Jun-23	2.3%	2.6%		F	Seven consecutive points above the mean Metric will consistently fail the target
	Bookings completed by 9+6 weeks gestation	Jun-23	50.5%	74.1%		P	Common cause variation Metric will consistenly pass the target
	Breast feeding initiated	Jun-23	72.7%	77.2%		?	Common cause variation Metric will inconsistently pass and fail the target
	Number of serious incidents	Jun-23	0.5	0		?	Common cause variation Metric will inconsistently pass and fail the target
	SLA income against plan (£m)	Jun-23	2.7	2.6		?	Common cause variation Metric will inconsistently pass and fail the target
Mortality	Crude mortality per 1,000 admissions In-month	Jul-23	12.8	10.7		?	Common cause variation Metric will inconsistently pass and fail the target
	Crude mortality per 1,000 admissions Rolling 12-months	Jul-23	12.8	11.3			Rolling 12-months - unsuitable for SPC
	HSMR In-month	May-23	100	90.2		?	Common cause variation Metric will inconsistently pass and fail the target
	HSMR Rolling 12-months	May-23	100	92.4			Rolling 12-months - unsuitable for SPC
	SHMI In-month	Feb-23	100	90.4		?	Common cause variation Metric will inconsistently pass and fail the target
	SHMI Rolling 12-months	Feb-23	100	90.4			Rolling 12-months - unsuitable for SPC

Month 04 | 2023-24

Quality

Summary

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Re-admissions	Number of emergency re-admissions within 30 days of discharge	May-23	n/a	680			Common cause variation No target
	Rate of emergency re-admissions within 30 days of discharge	May-23	9.0%	6.4%		P	Common cause variation Metric will consistently pass the target
Length of Stay	Average elective length of stay	Jul-23	2.8	2.4		?	Common cause variation Metric will inconsistently pass and fail the target
	Average non-elective length of stay	Jun-23	4.6	4.9		?	Common cause variation Metric will inconsistently pass and fail the target
Palliative Care	Proportion of patients with whom their preferred place of death was discussed	Jul-23	n/a	94.4%	H		9 points above the mean No target
	Individualised care pathways	Jul-23	n/a	40			Common cause variation No target

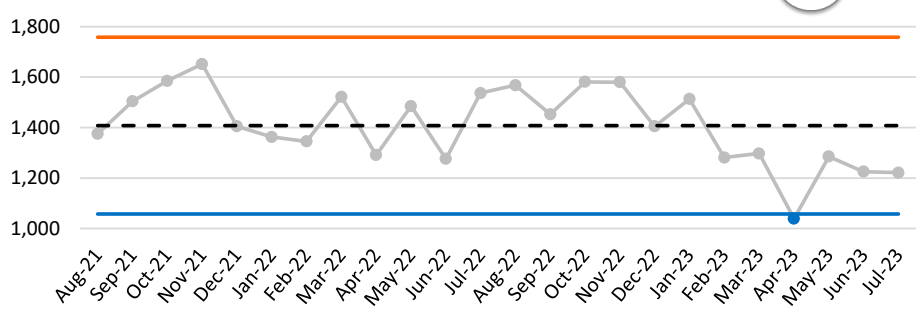
Month 04 | 2023-24

Quality

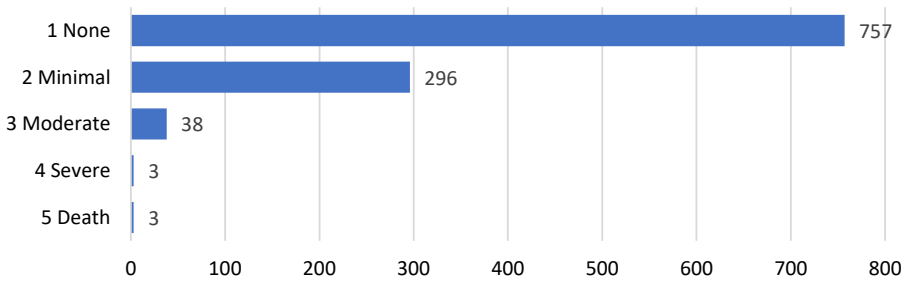
Patient Safety Incidents

East and North Hertfordshire NHS Trust

Total incidents reported



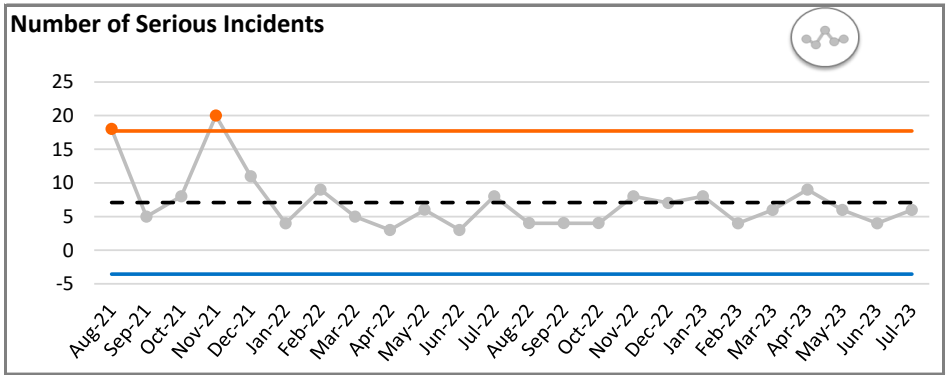
Number of patient safety incidents by level of harm - July-23



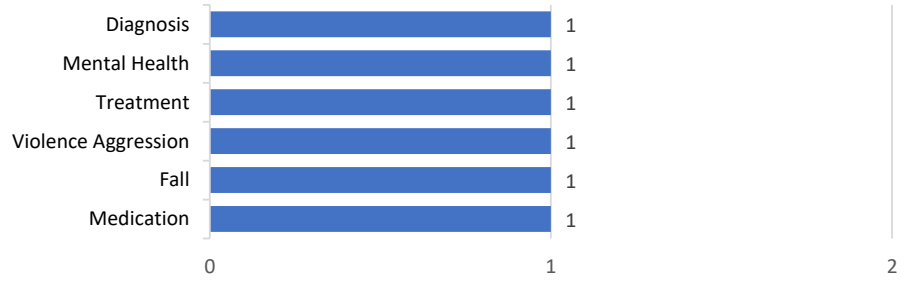
Key Issues and Executive Response

- Normal variation in incident reporting levels
- Of the patient safety incidents reported in month, 96% no/low patient harm, 3% moderate harm and 1% categorised as severe harm/death.
- Of the incidents reported in month, 178 have been closed, 365 are awaiting Divisional lead sign off and 694 are open being investigated.
- ED continues to be the highest reporting specialty of incidents followed by Acute Medicine and then Obstetrics.
- Normal variation in the number of new SIs declared in month (6).
- 11 SI's approved and submitted to the ICB (further improvement on last month and highest number in month since October 2022)
- Recent Never Event (wrong site block) submitted to ICB ahead of due date as anticipated
- Ongoing thematic review of incidents involving violence and aggression with patients with mental health needs (4 SI's being reviewed together). Multi-agency roundtable meeting scheduled for 6 September.
- High number of open SI investigations is recognised (35) with ongoing focus on ensuring momentum maintained with progressing the investigations and associated learning promptly.

Number of Serious Incidents



Serious Incidents Themes - July-23



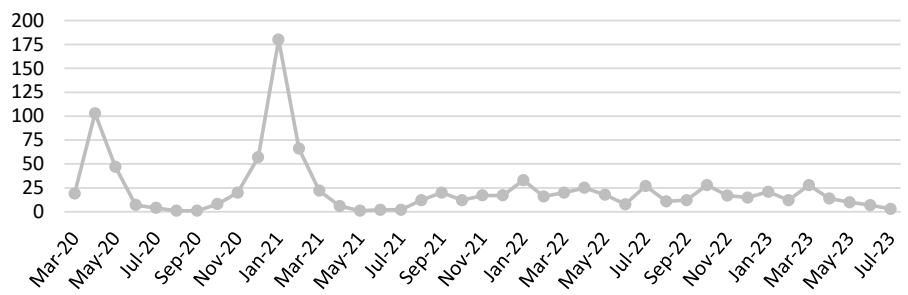
Month 04 | 2023-24

Quality

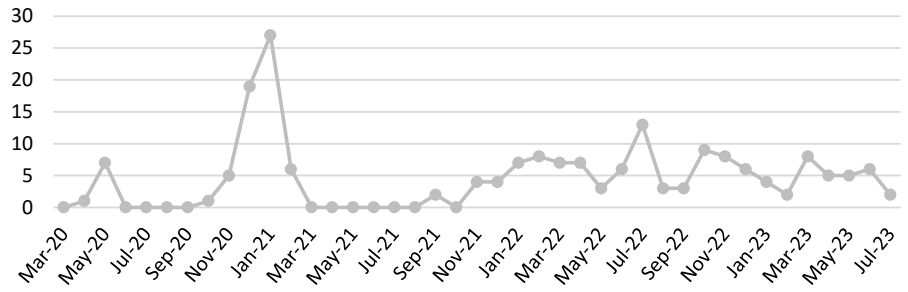
COVID-19

East and North Hertfordshire NHS Trust

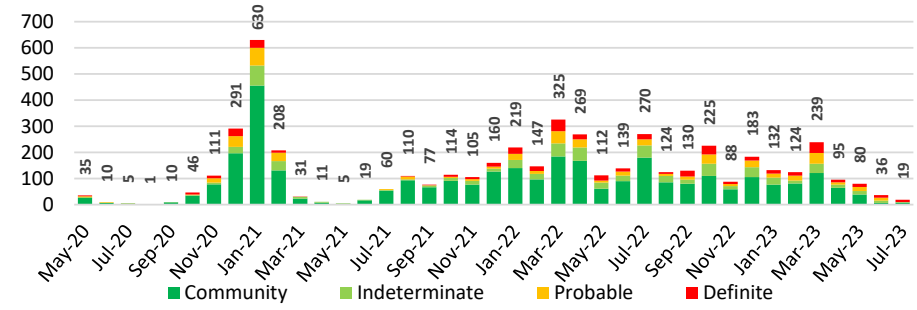
Number of deaths from COVID-19



Number of deaths from hospital-acquired COVID-19



COVID-19 cases by category



Key Issues and Executive Response

- The total number of inpatients with COVID in July continues to reduce to 53. Of these cases 21 were contributed to probable or definite hospital-onset COVID.
- Trust wide swabbing for COVID is now only undertaken for clinically indicated patients , therefore the sample of patients swabbed are significantly smaller and more likely to be positive.
- Of the total 3 patients who sadly died with a diagnosis of COVID in July, 2 of these cases were related to probable or definite hospital-onset COVID, and were treated for significant underlying comorbidities.
- Structured reviews are undertaken locally to capture learning where a hospital acquired infection has been identified. Where any potential harms are identified, the individual cases shall be represented to serious incident review panel for executive oversight.
- Mobile Redi rooms have been in use throughout July to support patient isolation without having to move patient form ward to ward.

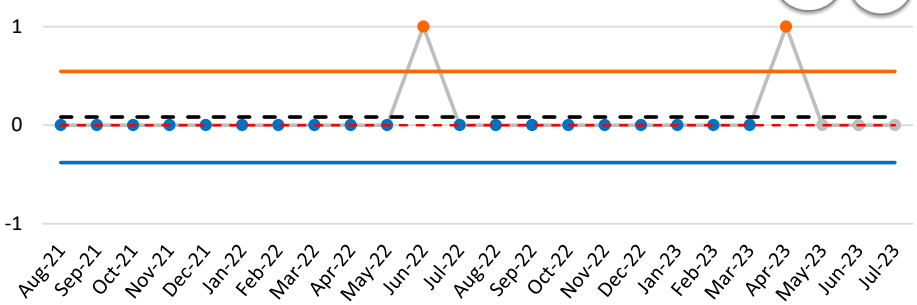
Month 04 | 2023-24

Quality

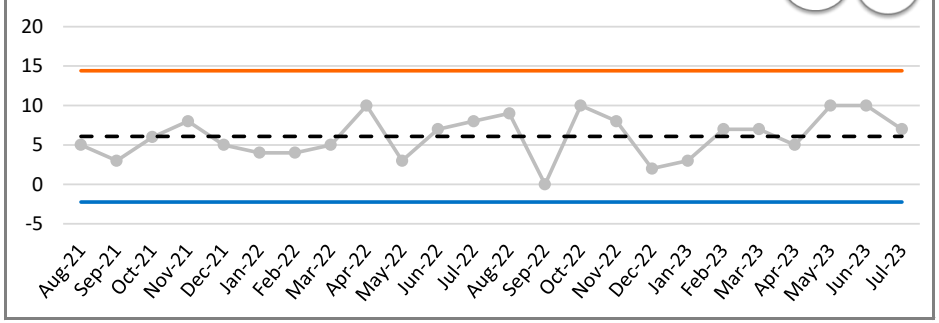
Infection Prevention and Control

East and North Hertfordshire NHS Trust

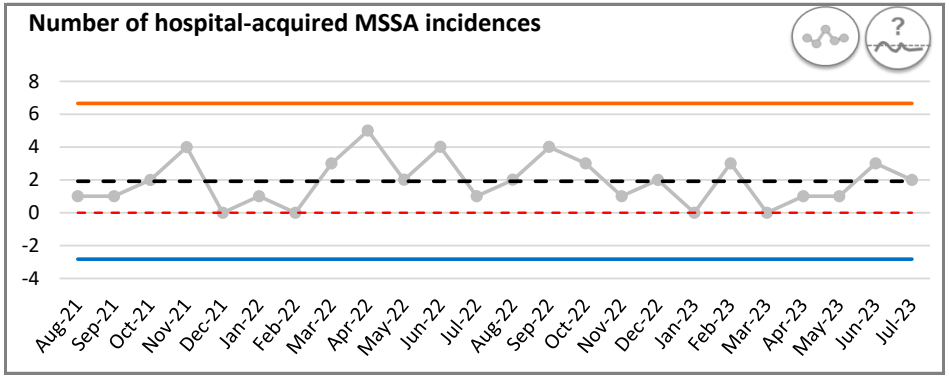
Number of hospital-acquired MRSA BSI incidences



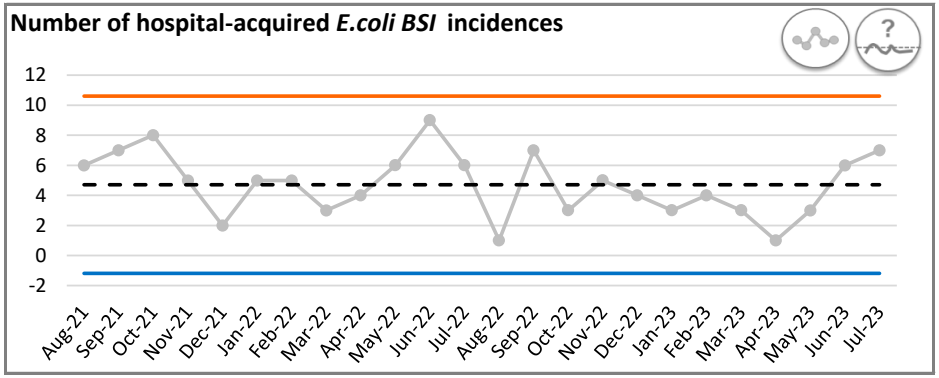
Number of hospital-acquired *C.difficile* incidences



Number of hospital-acquired MSSA incidences



Number of hospital-acquired *E.coli BSI* incidences



- *C difficile (C diff.)* - Year to date (YTD) cases remain above trajectory against the threshold of 58. There was a meeting involving the pharmacy team, Microbiology Consultant, IPC Team & the Respiratory Medical Consultant to review Trust policy for antimicrobial prescribing for the respiratory system, to ensure that any possible changes from broad spectrum to narrow spectrum antibiotics are made to decrease avoidable *C diff*. infections. A '*C difficile* HERTS & West Essex (HWE) System Summit' was held on 05/7/23 to support a systems approach to tackling the high rates of infection in the ICS. An action plan was been devised and is being implemented.

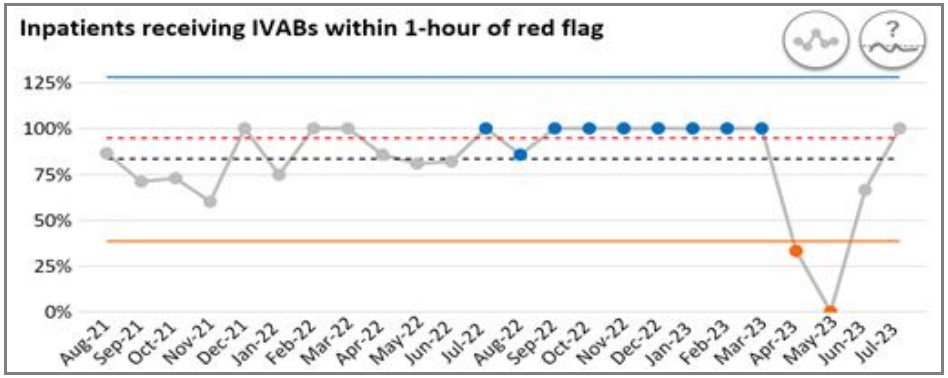
- MRSA BSI - there are no MRSA BSI in the month of July 2023.
- MSSA BSI - the rate remains below that of the same period in financial year 2022-2023. There is no threshold
- *E.coli BSI*- the Trust is currently slightly above trajectory for the month of July 2023, against the threshold of 44. Post infection reviews are currently being led by the IPC team and relevant wards to identify any learning to improve practice.

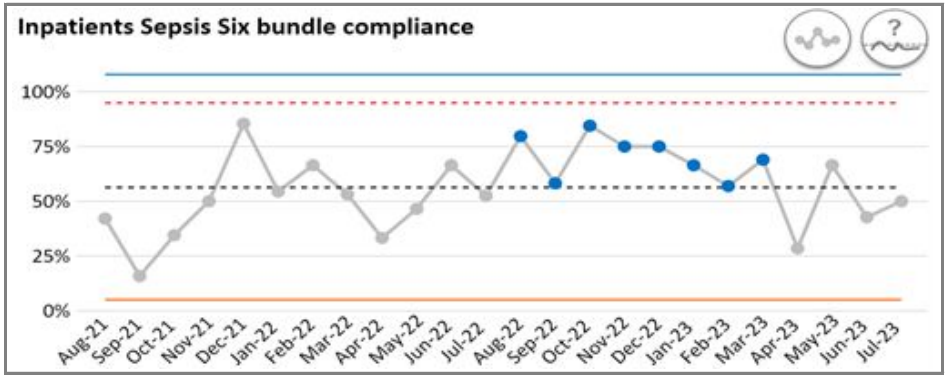
Month 04 | 2023-24

Quality

Sepsis Screening and Management | Inpatients

East and North Hertfordshire NHS Trust





Themes

Sepsis IP	2022-23								2023-24			
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%
Blood cultures	92%	86%	82%	83%	86%	88%	100%	100%	29%	100%	69%	67%
IV antibiotics	86%	92%	100%	100%	100%	100%	100%	100%	0%	0%	83%	100%
IV fluids	100%	75%	86%	100%	100%	100%	100%	67%	33%	100%	50%	56%
Lactate	89%	70%	83%	88%	80%	63%	62%	80%	43%	67%	54%	58%
Urine measure	87%	76%	100%	88%	88%	75%	86%	86%	71%	100%	64%	75%

Key Issues and Executive Response

Themes

- IV antibiotic compliance within the hour has improved to 100%, exceeding Trust targets.
- The overall sepsis six compliance shows normal variation with a slight improvement from 50 to 56%, which can be attributed to small improvements in IV fluid compliance, lactate measurement and urine output monitoring.
- Whilst slight improvements can be seen, IV fluid administration and lactate collection compliance remain low at 56% and 58% respectively.
- Average time to IV fluids was 80 minutes in July, exceeding the one hour target due to occasions where there were delays to fluids.
- The sepsis team was not informed of any serious harm or patient incidents related to sepsis throughout July.

Response

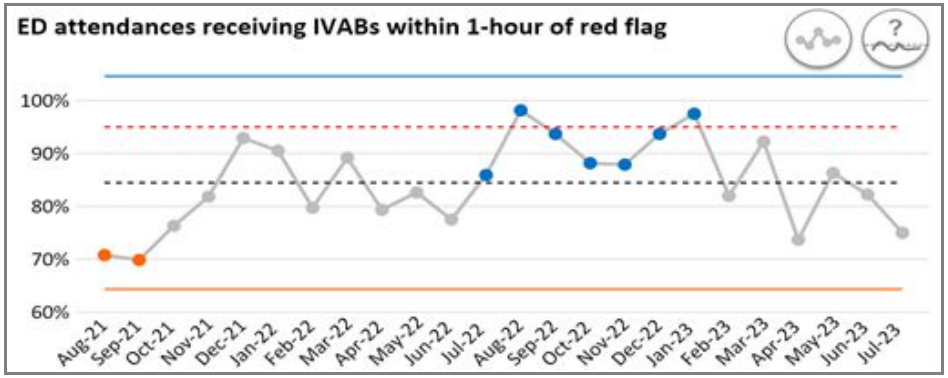
- Following multiple well-received extra sepsis teaching sessions in the planned care division, the Sepsis Team have organised further extra teaching sessions for planned care staff throughout August.
- The Sepsis Team have liaised with the unplanned Clinical Practice Team and educated them on the new sepsis screening tool with the aim of the Practice Development staff to begin promoting use of the tool in clinical areas.
- The Sepsis Team have also reached out to both Barley and Pirton ward managers for further teaching dates, as a starting point and then will progress throughout the rest of the hospital.
- The Sepsis Team will be delivering doctor's teaching, starting with IMT's in August and Foundation doctors in September.
- All other routine teaching continues (staff sepsis induction/BEACH/ENH Academy sepsis training)
- The Sepsis Team will be delivering a MDT simulation teaching day at the end of August, focused on management of sepsis and AKI.

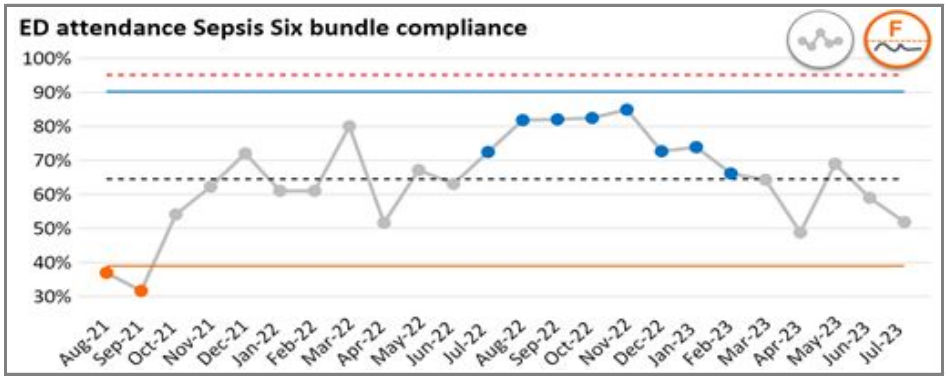
Month 04 | 2023-24

Quality

Sepsis Screening and Management | Emergency Department

East and North Hertfordshire NHS Trust





Themes

Sepsis ED	2022-23								2023-24			
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Oxygen	100%	100%	100%	100%	100%	100%	98%	100%	100%	95%	100%	98%
Blood cultures	98%	93%	88%	94%	93%	90%	90%	93%	87%	93%	90%	87%
IV antibiotics	98%	92%	88%	88%	94%	98%	82%	93%	74%	86%	82%	75%
IV fluids	96%	96%	93%	90%	92%	97%	85%	100%	84%	81%	79%	81%
Lactate	98%	97%	100%	97%	100%	100%	95%	100%	92%	96%	96%	95%
Urine measure	81%	84%	88%	94%	78%	81%	74%	79%	67%	80%	74%	68%

Key Issues and Executive Response

Themes

- IV antibiotic compliance within ED has decreased in July, at only 75% compliance due to delays leading to antibiotics being administered after 1 hour.
- Average time to IV antibiotics was 57% despite some cases of delays. Delays are often seen where sepsis patients are being treated in areas with high patient to nurse ratio such as waiting areas as opposed to resus.
- The overall sepsis six compliance within ED has also declined.
- A significant aspect of the poor sepsis six bundle compliance is due to poor urine output measurement compliance in July.
- IV fluid compliance shows normal variation but remains below targets.
- The Sepsis Team was not informed of any serious harm to any patients in relation to sepsis in July.

Response

- The Sepsis Team continue to clinically provide bedside education to newer/junior staff, often attending to sepsis patients in ED and going through the tool with ED nurses and doctors in real time.
- The Sepsis Team has also asked the ED practice development team to promote the correct use of the tool and their documentation to maximise sepsis six compliance.
- The Sepsis Team and the ED practice development team are promoting the use of digital fluid balance monitoring in the department to improve monitoring and urine measurement compliance.
- Improvements with the digital sepsis tool are still needed but staff have shown a positive response to the new tool and have shown some improvement in clear documentation where there is variation from the sepsis 6. The Sepsis Team continues to support with this.
- The Sepsis Team will be repeating the AKI/Sepsis simulation in August to help support with the care of septic patients.
- The Sepsis Team has organised foundation doctor teaching on sepsis in September.

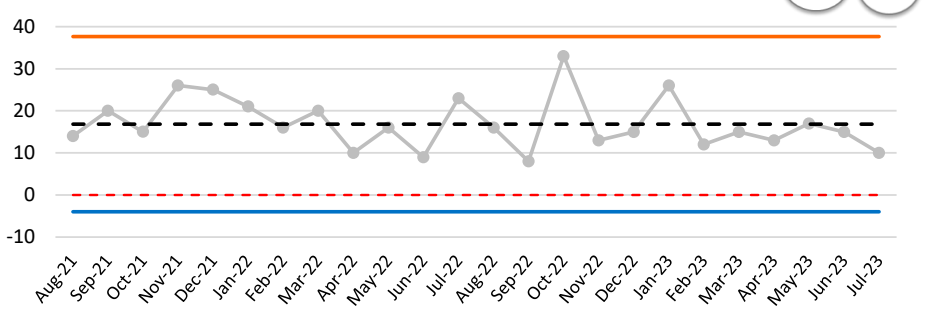
Month 04 | 2023-24

Quality

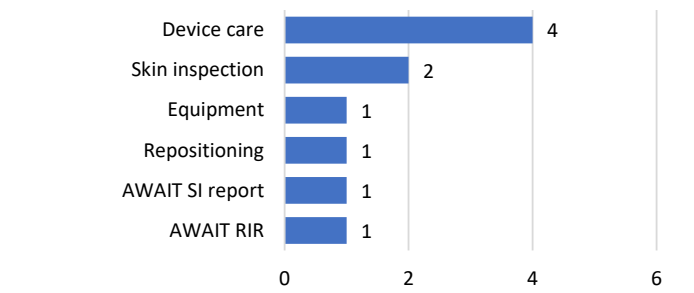
Pressure Ulcers | VTE

East and North Hertfordshire NHS Trust

Number of hospital-acquired pressure ulcers



Themes - July-23

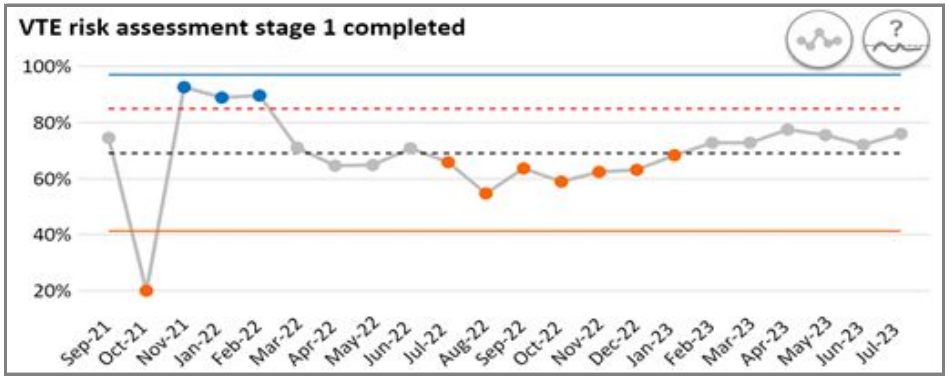


47

days since last category 4

as at 24/08/2023

VTE risk assessment stage 1 completed



Key Issues and Executive Response

- 1 serious harm reported due to skin damage in July. PU data remains within common cause variation.
- PU are split 50/50 Between Device related and standard PUs - QiP work is ongoing in CRCU with the trial of a new Urinary catheter fixation device.
- PU Risk assessment CQUIN is ongoing Q1 data is at 57% compliance with 6hr time frame and care planning. TVT engaging with wards to prioritise Risk assessment.
- TVT Actions FOR 2023/24
    - Continuation of face to face teaching to fulfil action plans from 22/23 SI reports. Dates for 2024 set and await publication.
    - Implementation of new National Wound Care Strategy Programme (NWCSP) PU recommendations.
    - Convert PU risk assessment tool to PURPOSE-T to align with the new NWCSP recommendations.

VTE

- Through the first quarter of 2023 several changes have been delivered to improve the reliability of VTE risk assessments at the point of clinical care during assessment and then documentation within our digital systems.
- These changes are incrementally improving the capture and visibility of the risk assessments.
- In the beginning of June the Trust implemented a 'combined' assessment and single measure in line with exemplar sites. Compliance is being closely monitored
- Several clinical areas have QI projects in progress and show local improvements. Data to be shared with specialities including presenting at individual RHDs.

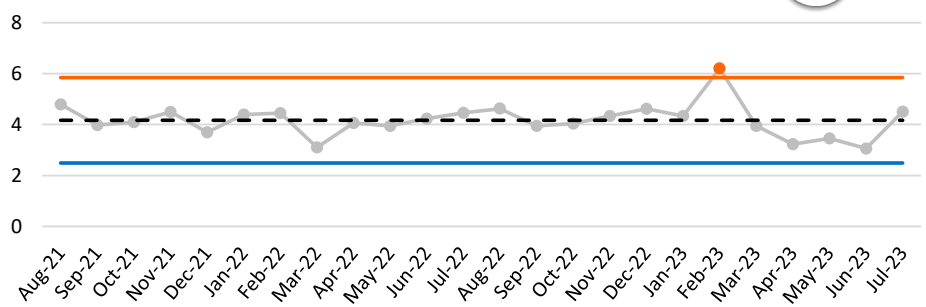
Month 04 | 2023-24

Quality

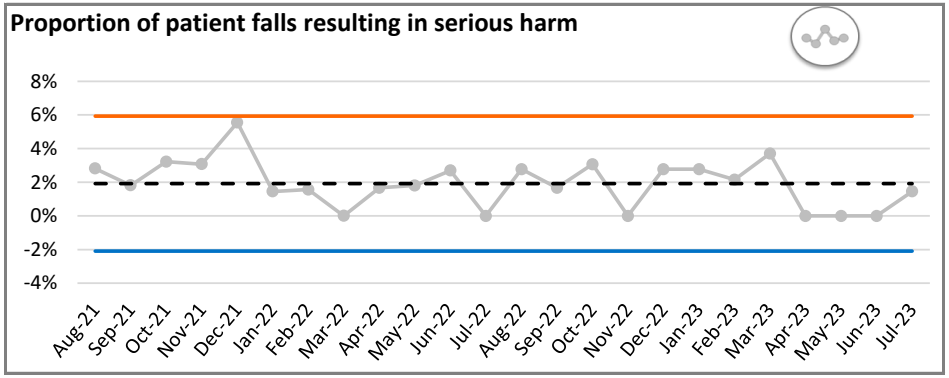
Patient Falls

East and North Hertfordshire NHS Trust

Rate of patient falls per 1,000 overnight stays



Proportion of patient falls resulting in serious harm



Key Issues and Executive Response

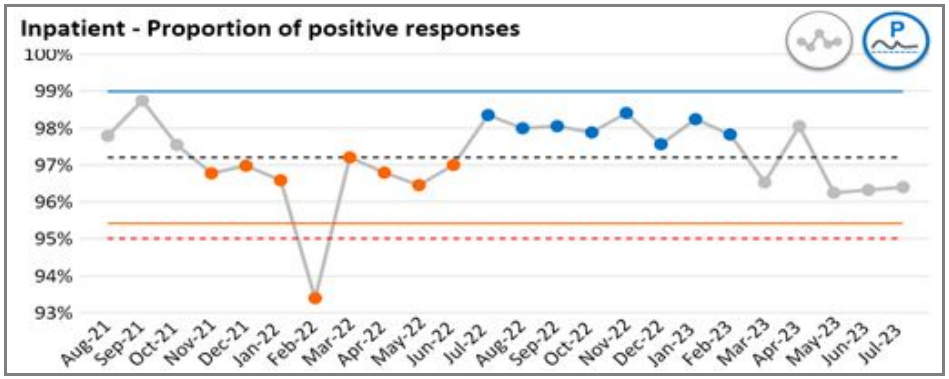
- Inpatient falls data continues to show common cause variation, with an average of 4 per month per 1000 bed days.
- Falls incidence in July has increased compared to the previous months.
- 1 severe harm and 3 moderate harms recorded for the month of July. Some of this were presented with local learning and adapting the ongoing falls prevention strategies focusing improvement with baywatch compliance and improvement compliance with falls documentation.
- ED needs continued support in completing falls risk assessment. This has been highlighted to their clinical educator, falls lead to attend team meetings to talk about falls documentation.

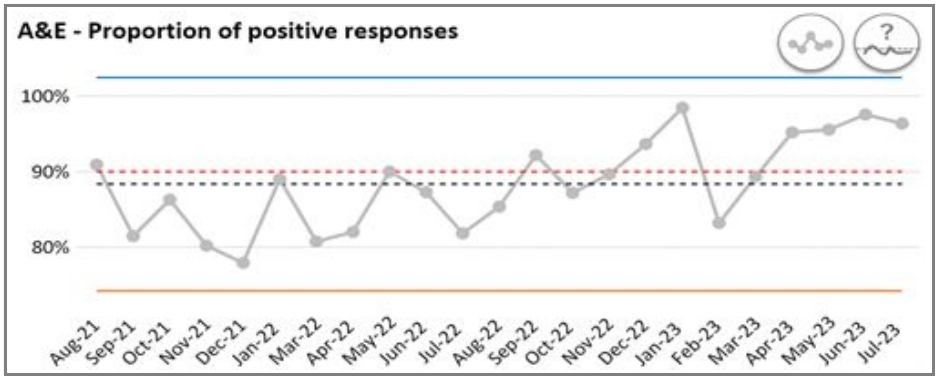
Month 04 | 2023-24

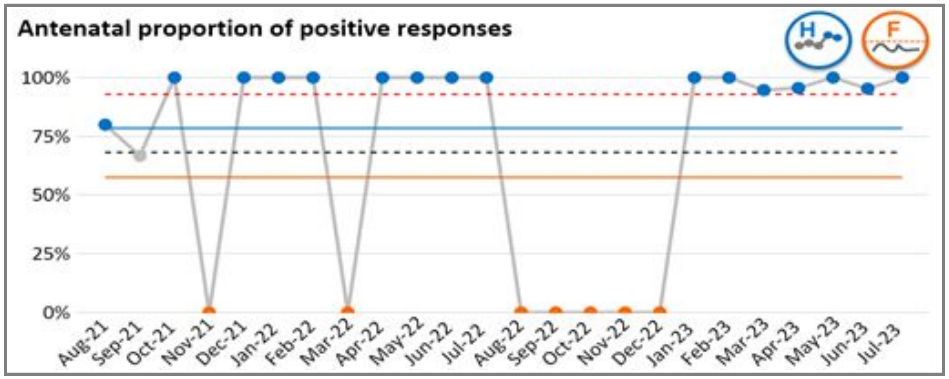
Quality

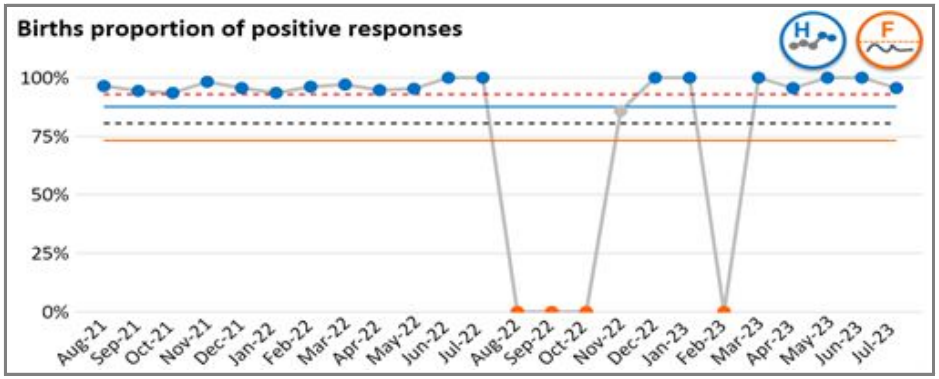
Friends and Family Test

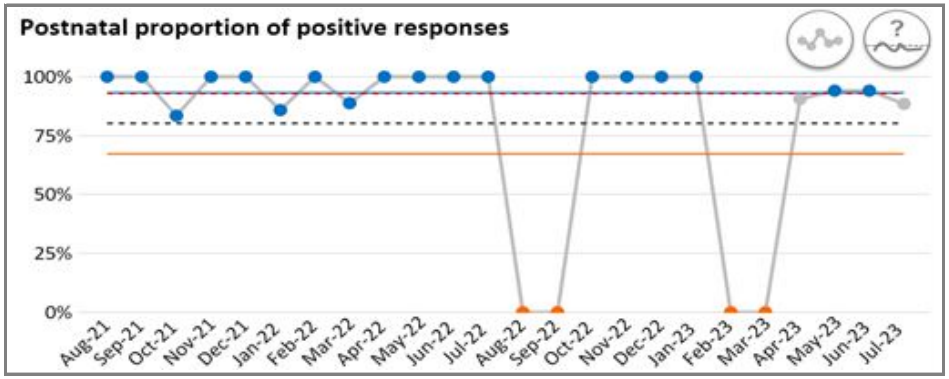
East and North Hertfordshire NHS Trust

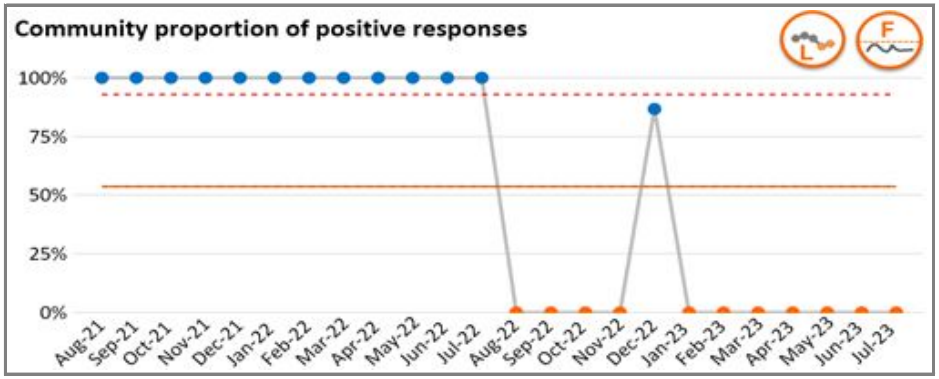










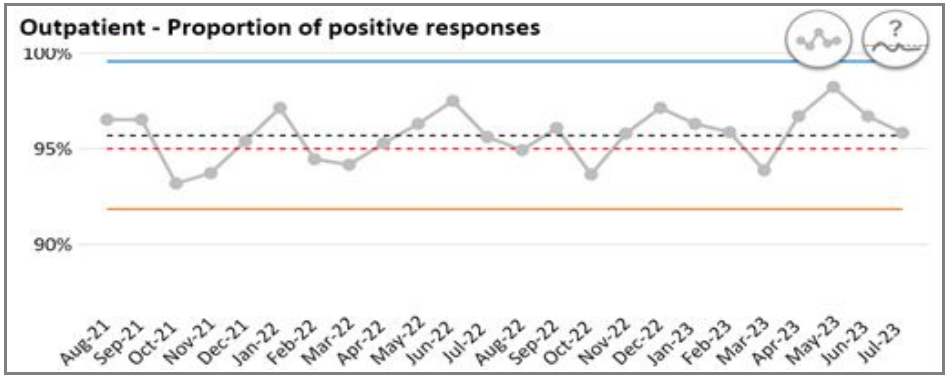


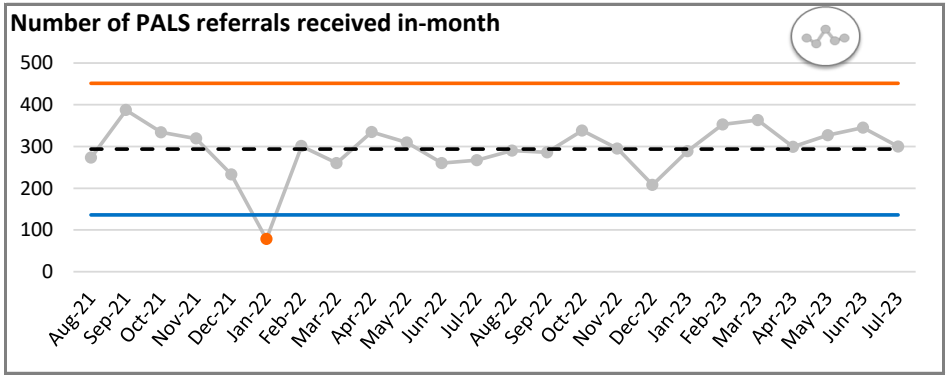
Month 04 | 2023-24

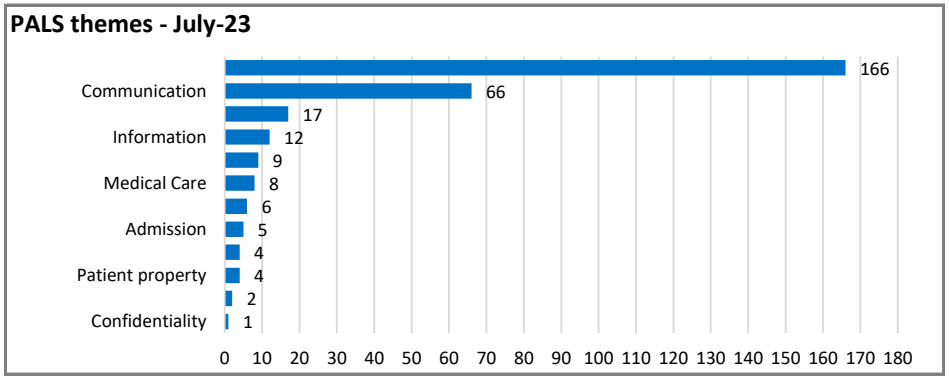
Quality

Friends and Family Test | Patient Advice and Liaison Service

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Friends and Family Test

Challenges

- Community midwifery continue to have zero responses. The Patient Experience team are currently working with maternity to look at why this is, and how we can make the QR codes available to people in the community - i.e. adding to a leaflet, and phone calls.

Actions

- Continue to promote the FFT survey within the divisions, advising how they can review their data on ENHance to take ownership of the findings.

Patient Advice Liaison Service

Excellence

- A rota has been drafted for staff to attend wards on a monthly basis when the case load becomes more manageable.

Challenges

- Emails have started to mount up within the department. This is due to the amount of emails and phone calls, when team members on leave etc, the risk / reality is that it does increase etc, despite the massive efforts to reduce.

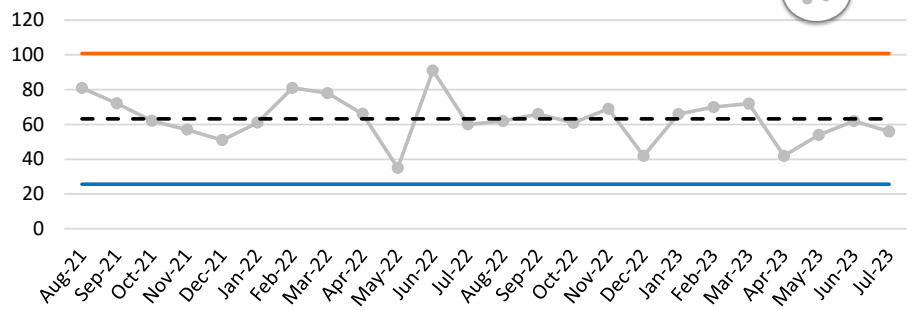
Month 04 | 2023-24

Quality

Complaints

East and North Hertfordshire NHS Trust

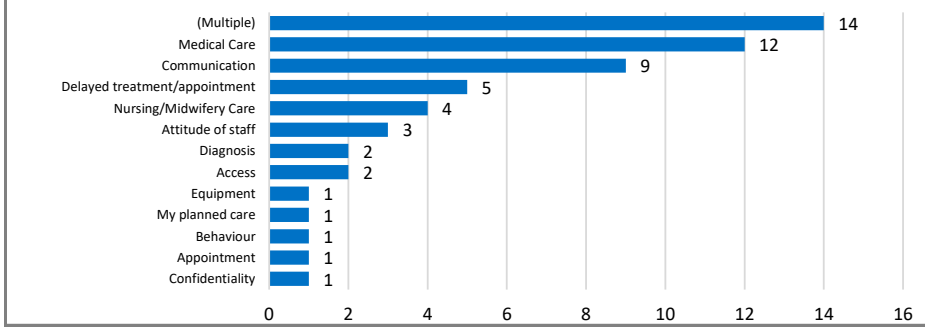
Number of written complaints received



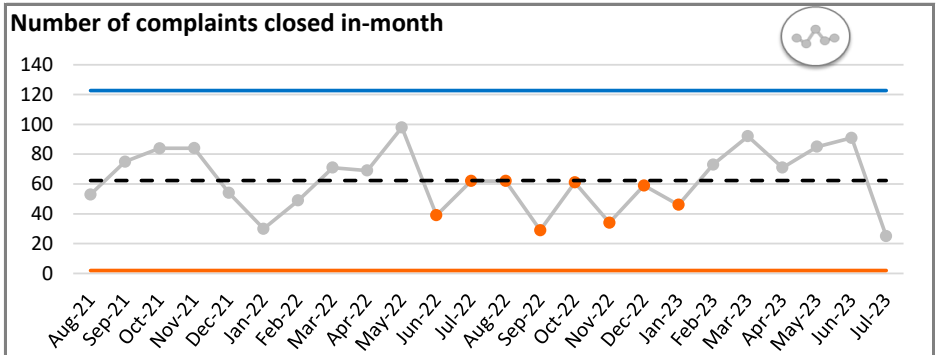
Key Issues and Executive Response

- 120 complaints remain open at the end of July, which is a continual improvement, and continues to reduce as the backlog of drafting is completed.
- Early resolution meeting process has now been introduced to ensure that meetings are being managed within the divisions to ensure a robust streamline process. This will be rolled out in Maternity first with the rest of the Trust to follow by the end of September.
- Acknowledging complaints within 3 working days hit 100% compliance in July.
- A new formal complaint and PALs policy has been approved within the policy review group and will go to Trust board in November.

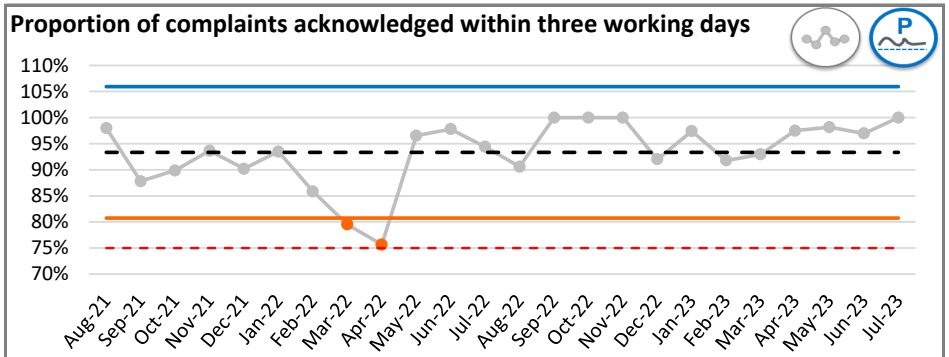
Complaints themes - July-23



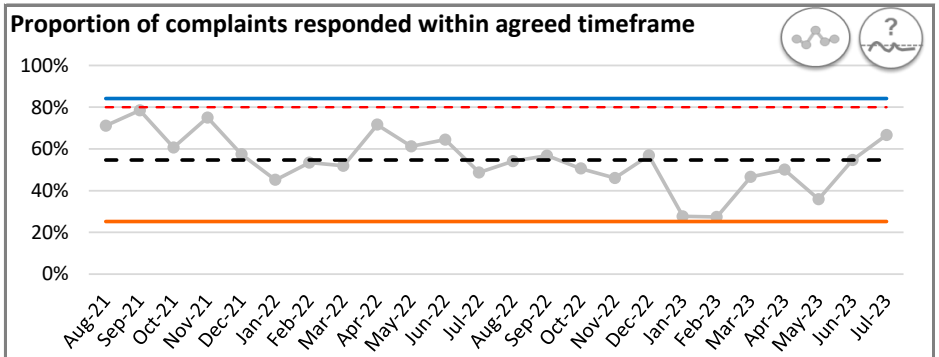
Number of complaints closed in-month



Proportion of complaints acknowledged within three working days



Proportion of complaints responded within agreed timeframe



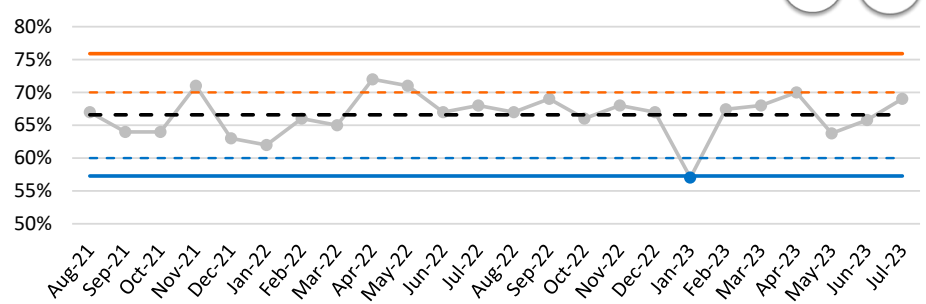
Month 04 | 2023-24

Quality

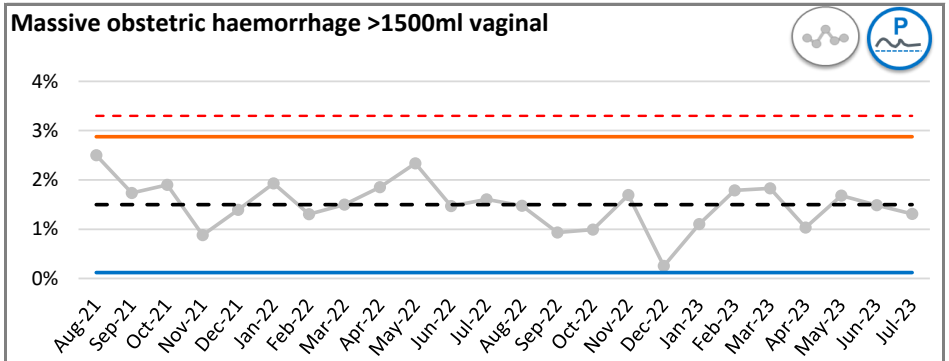
Maternity | Safety Metrics

East and North Hertfordshire NHS Trust

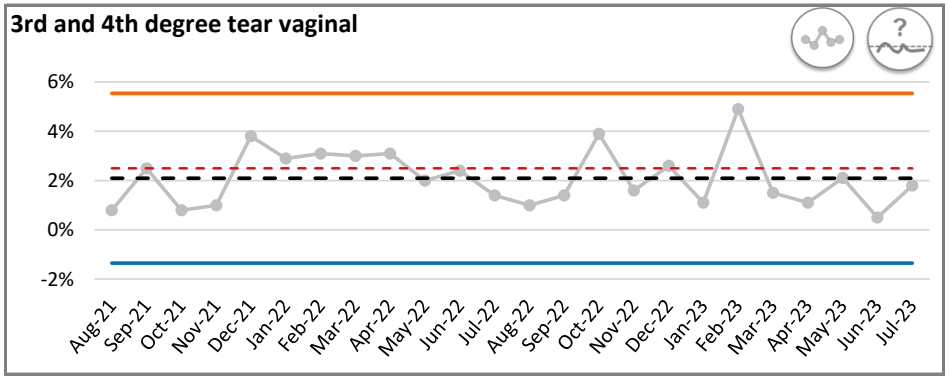
Total caesarean section rate from RG1, 2 and 5 combined



Massive obstetric haemorrhage >1500ml vaginal



3rd and 4th degree tear vaginal



Key issues and executive response

- No SI or HSIB cases this month and no ITU admissions.
- Smoking at booking remains below 6%. While concerning special cause variation is noted in relation to smoking rates at time of delivery, there are 4 points below the mean of a decreasing trend. Comparison data between booking and delivery is not directly comparable (these are different cohorts of women.
- 3rd / 4th degree tears - Normal variation noted. 2023 Cases are significantly below 2022 numbers currently. Monthly audit continues and a working party is now in place to implement the Obstetric anal sphincter injury (OASI) 2 care bundle as a quality improvement initiative.
- Massive Obstetric Haemorrhage (MOH) - Normal variation continues. Cases continue to be reviewed by the risk management MDT on a monthly basis.
- Breast feeding initiated at birth continues at around 75% which remains above the national average and within the interquartile range of all organisations compared within the national maternity dashboard.

Robson Group Criteria

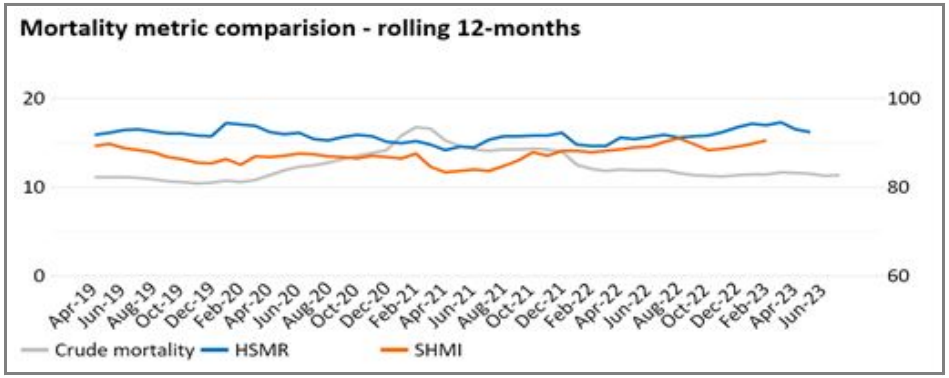
- This considers the obstetric variables to enable classification into one of 10 groups. This categorisation assists in understanding the reasons for the increasing trend in caesarean section rates.
    - **Robson group 1**: Nulliparous singleton pregnancy > 37 weeks with spontaneous labour onset.
    - **Robson group 2**: Nulliparous singleton pregnancy > 37 weeks delivered before labour onset or where labour induced.
    - **Robson group 5**: Multiparous women, singleton pregnancy >37 weeks with at least one previous uterine scar.
- These 3 groups combined normally contribute to 2/3rds of all CS performed in most hospitals.

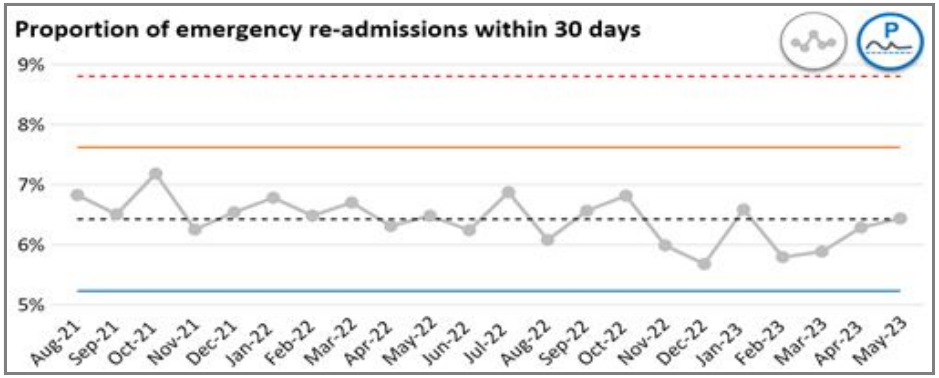
Month 04 | 2023-24

Quality

Mortality Summary | Emergency Re-admissions

East and North Hertfordshire NHS Trust





Key Issues and Executive Response

Mortality Metrics

- Following the rise in crude mortality seen during the pandemic, levels are now stable and slightly above those seen prior the pandemic.
- Despite increases to both HSMR and SHMI we continue to be well placed vs national peers. After a prolonged upward trend, rolling 12-month HSMR has seen a two month reduction.

Learning from Deaths

- Reforms continue regarding the Trust's learning from deaths framework, including the adoption of an SJRPlus Review format, developed by NHSE which commenced on 1 July 2022. Reforms include the reduction in the number of reviews undertaken, with the focus being on gaining richer learning from the process.
- From December 2022 the on-line SJRPlus tool migrated from the NHSE ORIS platform to NHS Apps.
- The SJRPlus review format, adopted by the Trust in July 2022 has provided an opportunity to revisit our broader learning from deaths processes, to take into account recent and imminent changes in the fields of scrutiny, quality, and governance, including the introduction of the Medical Examiner function and the forthcoming introduction of the new PSIRF approach to patient safety.
- To provide additional clarity and focus, a Learning from Deaths Strategy (2022-24) was developed which aligns with the Trust's overarching strategy and the Quality strategy. The strategy was approved by the Mortality Surveillance Committee in November 2022. An update on progress at year-end will be included in September Learning from Deaths report to Q&SC.

Re-admissions

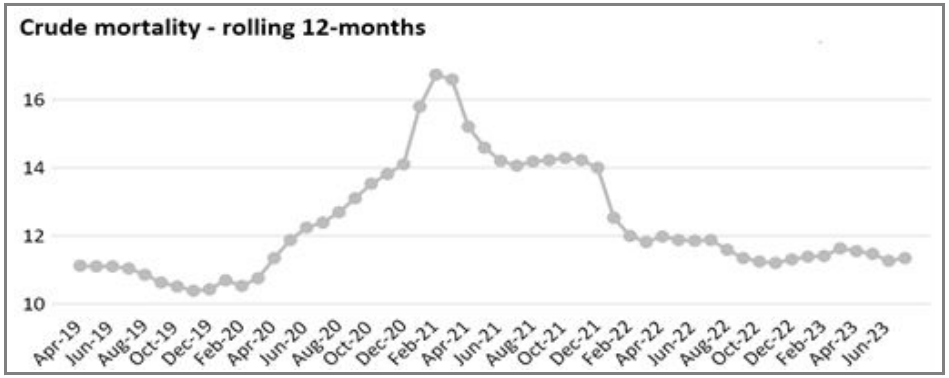
- The Trust's re-admissions performance for both readmissions within 30 days and for the rate of readmissions within 30 days remains relatively stable but with an upward trend for both over the last 3 months.
- The Trust's performance is well positioned in comparison to national and our Model Hospital peer group.

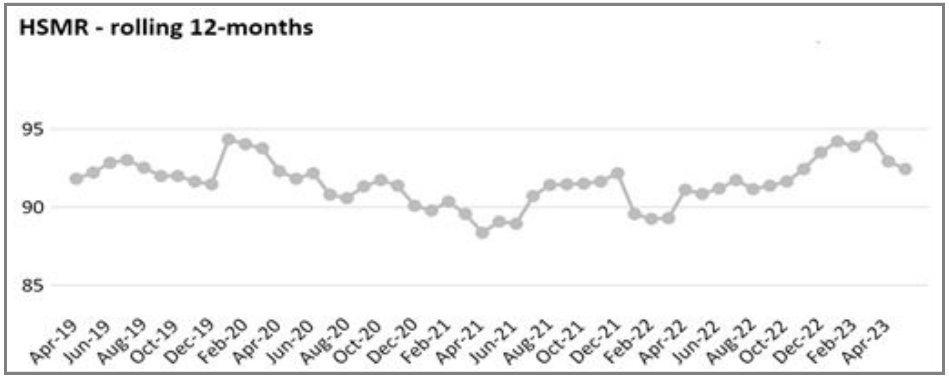
Month 04 | 2023-24

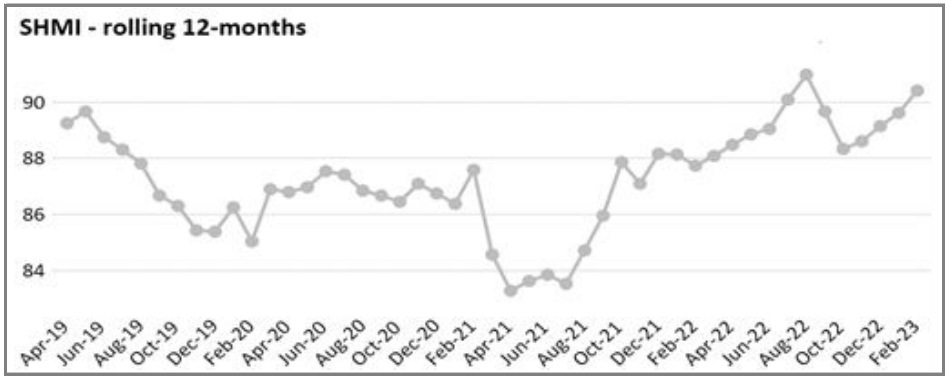
Quality

Mortality

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

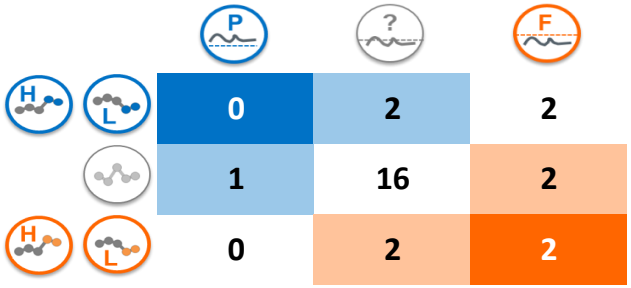
- Crude mortality is the factor which usually has the most significant impact on HSMR. The exception has been during the COVID pandemic, when the usual correlation has been weakened by the partial exclusion of COVID-19 patients from the HSMR metric.
- The general improvements in mortality prior to the COVID-19 resulted from corporate level initiatives such as the learning from deaths process, focussed clinical improvement work. Of particular importance has been the continued drive to improve the quality of our coding.
- While the COVID-19 pandemic saw peaks in April 2020 and January 2021, most of the intervening and subsequent periods have seen us positioned below, or in line with, the national average.
- Up to March 2023, there had been a gradual upward trend in rolling 12-month HSMR since December 2021. This contrasted with a downward trend in crude mortality for the same period, which is unusual as HSMR tends to follow the crude metric. HSMR has since seen 2 consecutive reductions. The situation continues to be monitored and discussed with CHKS.
- Our rolling 12-month HSMR data to May 2023 (94.6) shows that while the Trust has remained well positioned compared to our Model Hospital Peer group, it has slipped into the mid-range of trusts nationally.
- The latest in-month position for January 2023 reported by CHKS shows common cause variation.
- Latest NHSD published rolling 12-month SHMI to March 2023 showed a marginal increase from 92.30 to 92.95.
- Despite the increase the Trust remains well placed in the 'as expected band 2, in the top quartile of trusts nationally.

Month 04 | 2023-24

East and North Hertfordshire NHS Trust

Operations

Month 04 | 2023-24



Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Emergency Department	Patients waiting no more than four hours from arrival to admission, transfer or discharge	Jul-23	95%	65.2%	L	F	10 consecutive points below the mean Metric will consistently fail the target
	Patients waiting more than 12 hours from arrival to admission, transfer or discharge	Jul-23	2%	5.9%	L	F	One point below the lower process limit Metric will inconsistently pass and fail the target
	Percentage of ambulance handovers within 15-minutes	Jul-23	65%	14.8%	H	F	One point above the upper process limit Metric will consistently fail the target
	Time to initial assessment - percentage within 15-minutes	Jul-23	80%	46.3%		F	Common cause variation Metric will consistently fail the target
	Average (mean) time in department - non-admitted patients	Jul-23	240	212.9	H	?	10 consecutive points above the upper process limit Metric will consistently pass the target
	Average (mean) time in department - admitted patients	Jul-23	tbc	529.6	L		Common cause variation No target
	Average minutes from clinically ready to proceed to departure	Jul-23	tbc	237	L		One point below the lower process limit No target
	Critical time standards	Jul-23	tbc				Pending data
RTT & Diagnostics	Patients on incomplete pathways waiting no more than 18 weeks from referral	Jul-23	92%	49.5%	L	F	8 consecutive points below the mean Metric will consistently fail the target
	Patients waiting more than six weeks for diagnostics	Jul-23	0%	39.7%		F	Common cause variation Metric will consistently fail the target

Month 04 | 2023-24

Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Cancer Waiting Times	Two week waits for suspected cancer	Jun-23	93%	94.7%			Common cause variation Metric will inconsistently pass and fail the target
	Two week waits for breast symptoms	Jun-23	93%	98.8%			Common cause variation Metric will inconsistently pass and fail the target
	28-day faster diagnosis	Jun-23	75%	76.4%			Common cause variation Metric will inconsistently pass and fail the target
	31-days from diagnosis to first definitive treatment	Jun-23	96%	96.2%			Common cause variation Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - anti-cancer drugs	Jun-23	98%	100.0%		P	Common cause variation Metric will consistently pass the target
	31-days for subsequent treatment - radiotherapy	Jun-23	94%	65.7%	L		3 points below the lower process limit Metric will inconsistently pass and fail the target
	31-days for subsequent treatment - surgery	Jun-23	94%	91.3%			Common cause variation Metric will inconsistently pass and fail the target
	62-days from urgent GP referral to first definitive treatment	Jun-23	85%	81.7%			Common cause variation Metric will inconsistently pass and fail the target
	Patients waiting more than 104-days from urgent GP referral to first definitive treatment	Jun-23	0	4.0			Common cause variation Metric will inconsistently pass and fail the target
	62-days from referral from an NHS screening service to first definitive treatment	Jun-23	90%	90.9%			Common cause variation Metric will inconsistently pass and fail the target
	62-days from consultant upgrade to first definitive treatment	Jun-23	n/a	77.4%			Common cause variation No target

Month 04 | 2023-24

Operations

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Stroke Services	Trust SSNAP grade	Q1 2023-24	A	D			
	4-hours direct to Stroke unit from ED	Jul-23	80%	43.7%	H	?	One point above the upper process limit Metric will inconsistently hit and miss the target
	% of patients discharged with a diagnosis of Atrial Fibrillation and commenced on anticoagulants	Jul-23	63%	100.0%		?	Common cause variation Metric will inconsistently hit and miss the target
	4-hours direct to Stroke unit from ED with Exclusions (removed Interhospital transfers and inpatient Strokes)	Jul-23	63%	42.6%	H	?	One point above the upper process limit Metric will inconsistently hit and miss the target
	Number of confirmed Strokes in-month on SSNAP	Jul-23	n/a	84			Common cause variation No target
	If applicable at least 90% of patients' stay is spent on a stroke unit	Jul-23	80%	96.1%		?	Common cause variation Metric will inconsistently hit and miss the target
	Urgent brain imaging within 60 minutes of hospital arrival for suspected acute stroke	Jul-23	50%	65.9%		?	Common cause variation Metric will inconsistently hit and miss the target
	Scanned within 12-hours - all Strokes	Jul-23	100%	98.8%		?	Common cause variation Metric will inconsistently hit and miss the target
	% of all stroke patients who receive thrombolysis	Jul-23	11%	10.8%		?	Common cause variation Metric will inconsistently hit and miss the target
	% of patients eligible for thrombolysis to receive the intervention within 60 minutes of arrival at A&E (door to needle time)	Jul-23	70%	66.7%		?	Common cause variation Metric will inconsistently hit and miss the target
	Discharged with JCP	Jul-23	80%	89.3%		?	Common cause variation Metric will inconsistently hit and miss the target
	Discharged with ESD	Jul-23	40%	73.2%		?	Common cause variation Metric will inconsistently hit and miss the target

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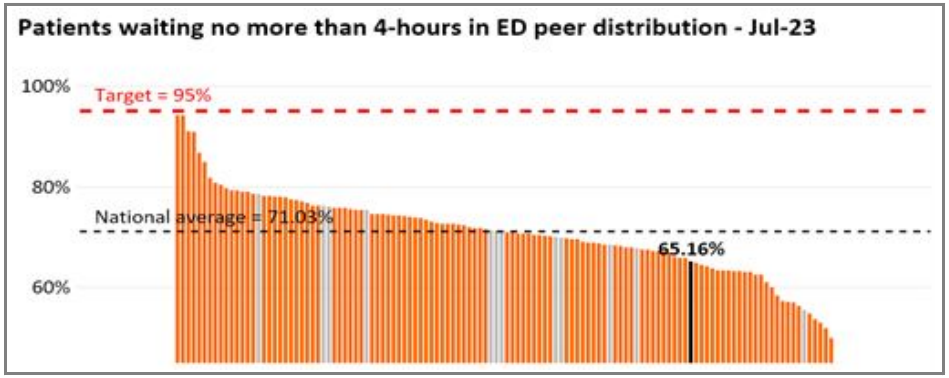
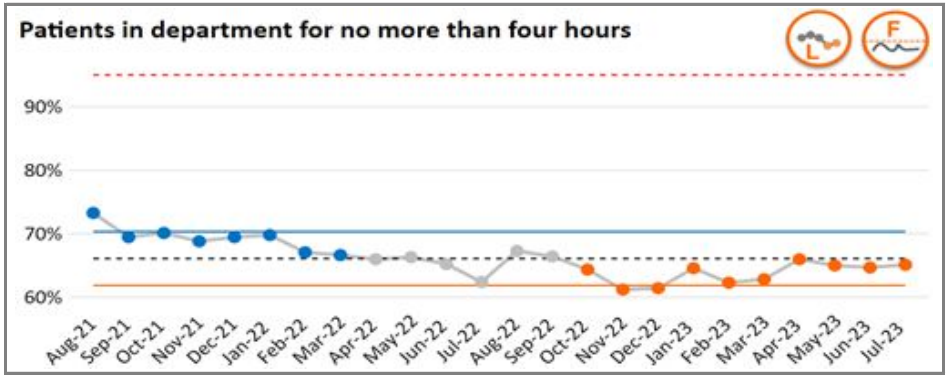
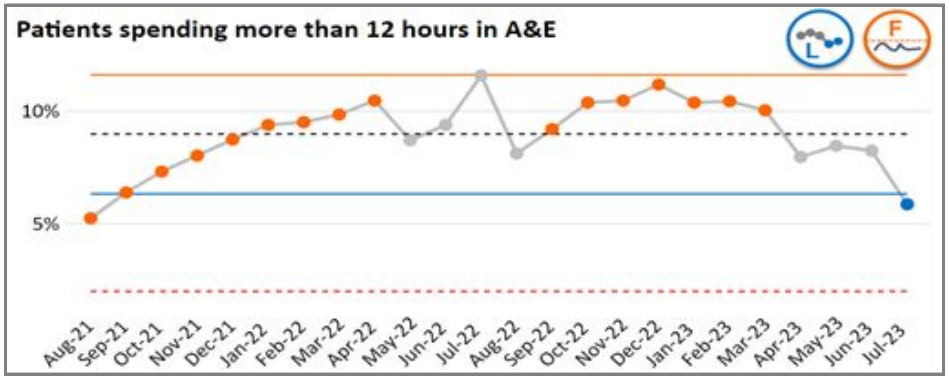
Operations

Emergency Department

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- Monthly attendances remained high, however, a reduction compared to last month. ENHT continues to support some focussed work around nursing home attendances and also have commenced planning for a co-located UTC at Lister to redirect a majority of minor injuries and illness currently attending ED.
- Performance against a majority of the emergency professional standards showed improvement this month with more than 12hours length of stay, total LOS for admitted patients and ambulance handover being the most notable improvements. Time delays from Clinically Ready To Proceed (CRTP) to transfer and/or discharge showed a dramatic improvement with its lowest avg. time since the Trust began recording CRTP. Further improvements will be achieved through delivery of the Urgent and Emergency Care (UEC) Programme which commenced in July. Also an ED demand and capacity review has taken plan and has highlighted some key opportunities to further improve and sustain efficiency within ED to reduce waits to be seen, length of stay and quality and safety.
- Ambulance performance remained stable compared to previous months with significant improvement in ambulances handed over within 30minutes, however it still remains significantly below the standard we want to be achieving. Focus continues in reducing LOS of patients in ambulance handover cubicles to enable release of space to support timely handovers.
- Bed days for patients 'not meeting the criteria to reside' increased for the third consecutive month and reached its highest level since August 2021. This continued to impact on UEC flow and the percentage of patients spending more than 12 hours in ED. Focus on pre-hospital utilisation of hospital at home continued as well as key workstreams to increase discharges via the same service.

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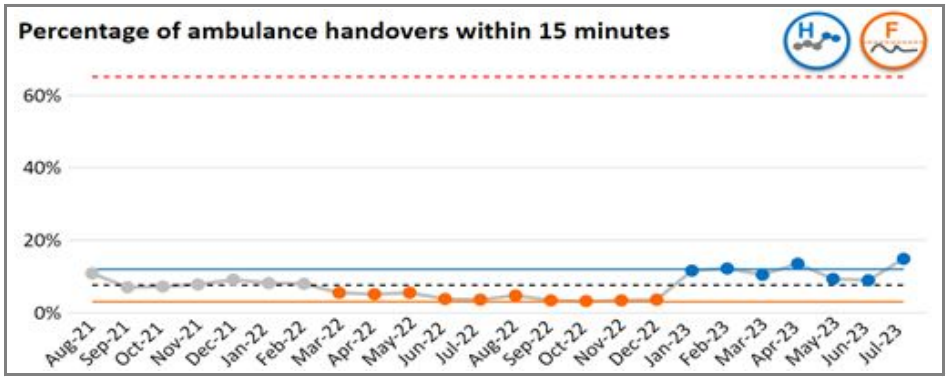
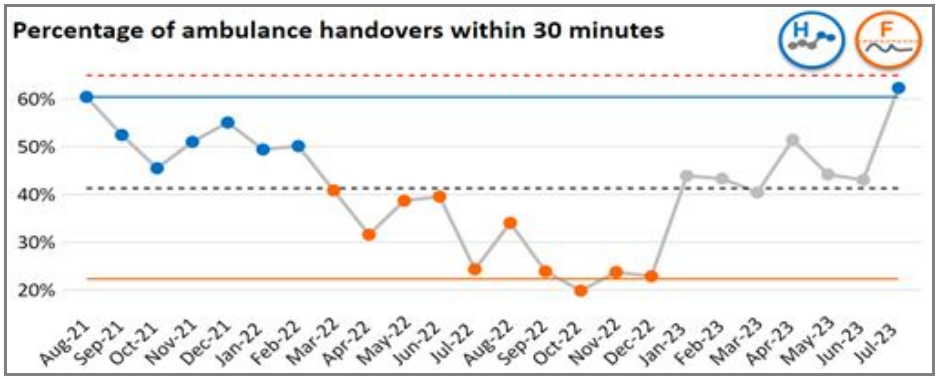
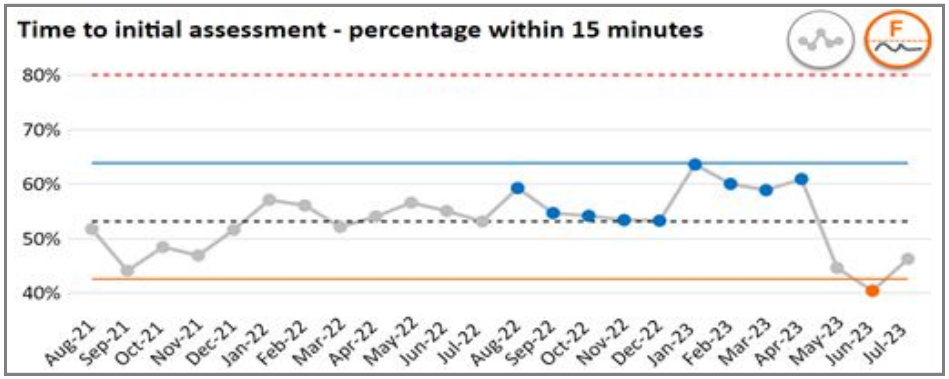
Operations

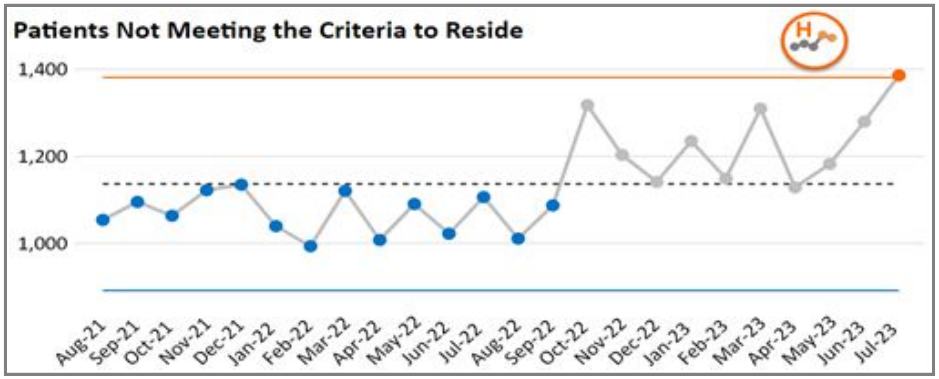
Emergency Department New Standards

East and North Hertfordshire NHS Trust







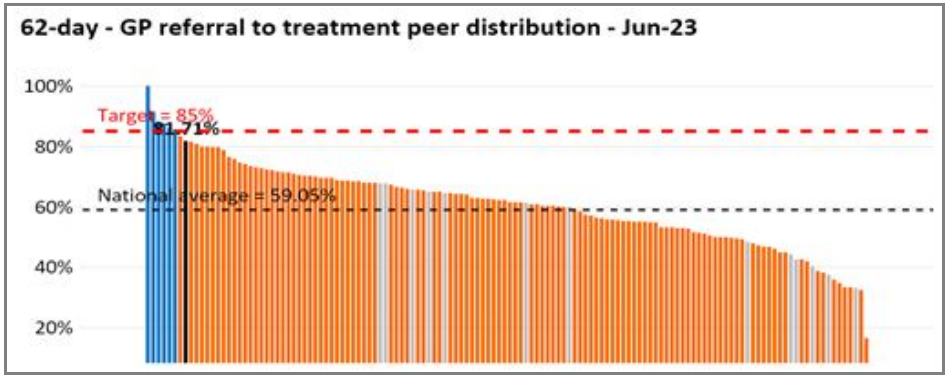


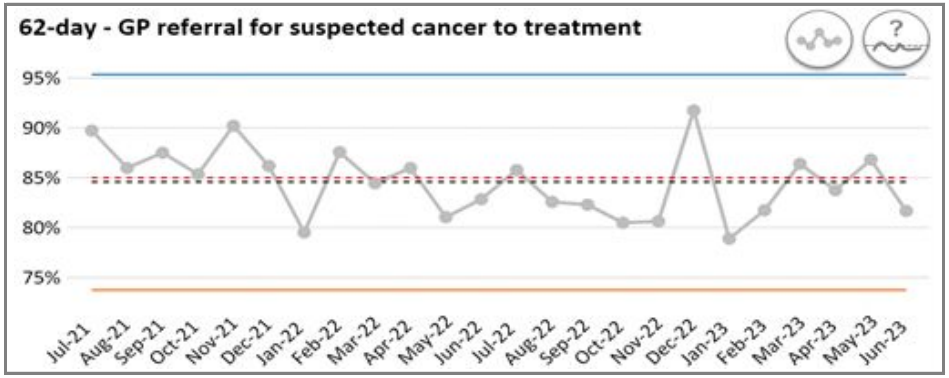
Month 04 | 2023-24

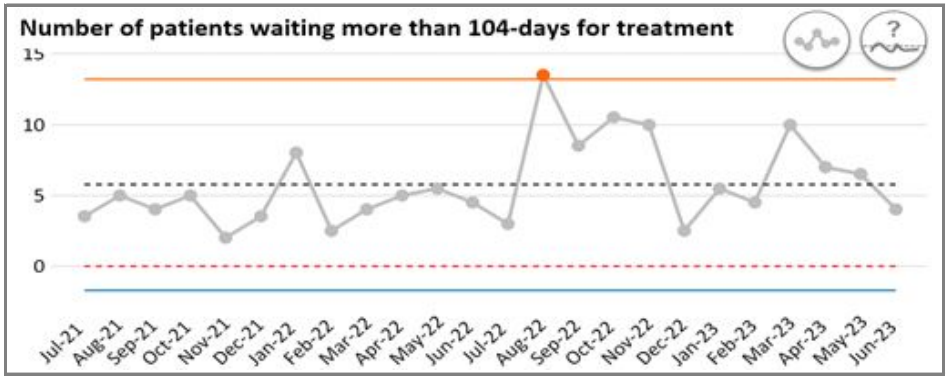
Operations

Cancer Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

- The Trust has been removed from Tier 2 for cancer as a result of progress with reducing the 62-day pathway backlog. Weekly monitoring has moved to monthly oversight.
- We achieved 6 of the 9 national targets in June with compliance in 2 week waits (2ww) for GP referrals, 2ww breast symptoms, 31-day first treatment, 31-day second or subsequent treatment for chemotherapy, 28 faster diagnosis standard (FDS) and 62-day referral to treatment for screening.
- 31-day subsequent treatments for surgery is non compliant due to theatre capacity for Skin and breast. Additional WLI agreed to cover backlog.
- 31-day subsequent treatment performance for radiotherapy has deteriorated due to high number of referrals, staff vacancies and delayed linac replacement. This has been escalated to regulators and performance compliance is due to recover by the beginning of September. This will be achieved through Saturday lists, use of the recruitment and retention premia and strong recruitment pipelines.
- 62-day referral to treatment performance is non compliant due to colonoscopy capacity which is being sought from independent sector, patient choice delaying the diagnostic pathway, TP biopsy capacity for Urology pathway which has now been increased by adding an extra case per list, Breast radiology delays and not being able to offer one stop service this has been now addressed with a Locum radiologist and also complex pathways which patient needed additional tests outside the Trust and multi MDT Tumour Site discussions.
- Work continues with Interim Management And Support (IMAS) around pathway analysis, to identify constraints in tumour level pathways and whole Trust cancer training.
- Breach analysis continues for all patients against all standards to influence pathway redesign and learning.

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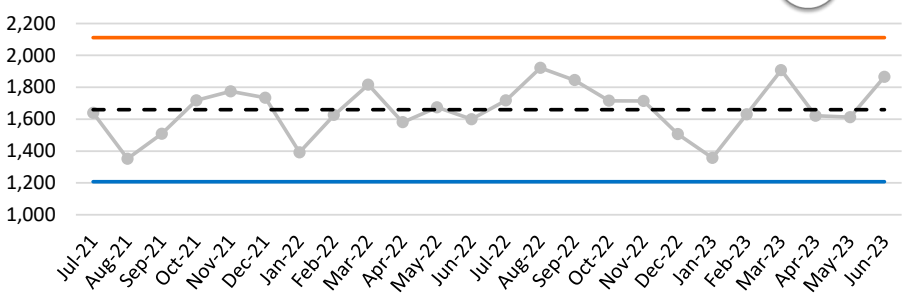
Operations

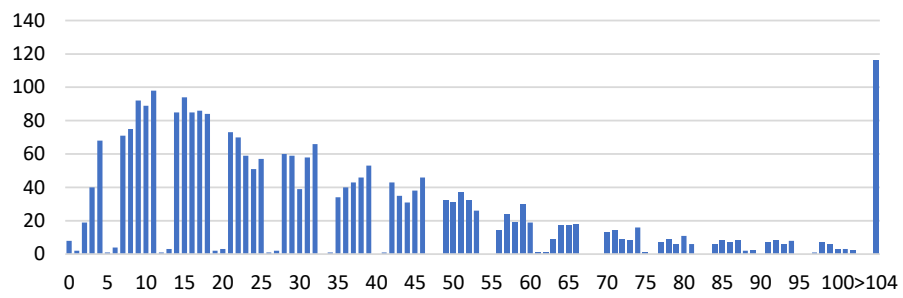
Cancer Waiting Times | Supporting Metrics

East and North Hertfordshire NHS Trust

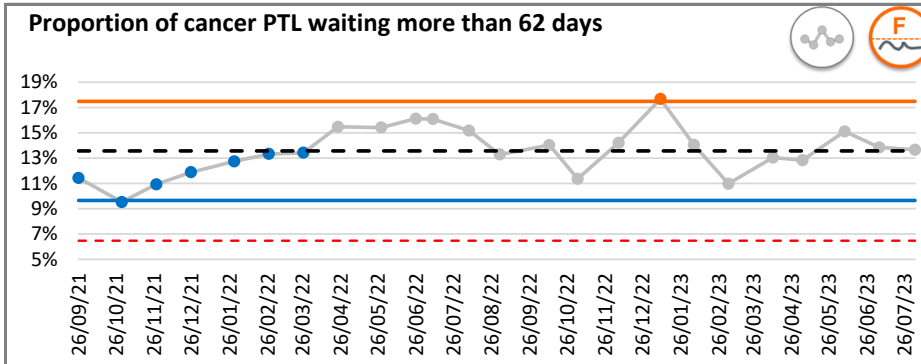
Suspected cancer referrals



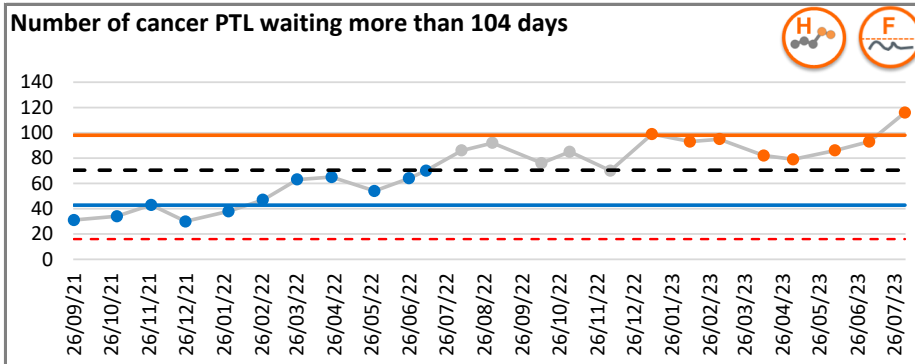
62-day PTL as at 04/08/2023



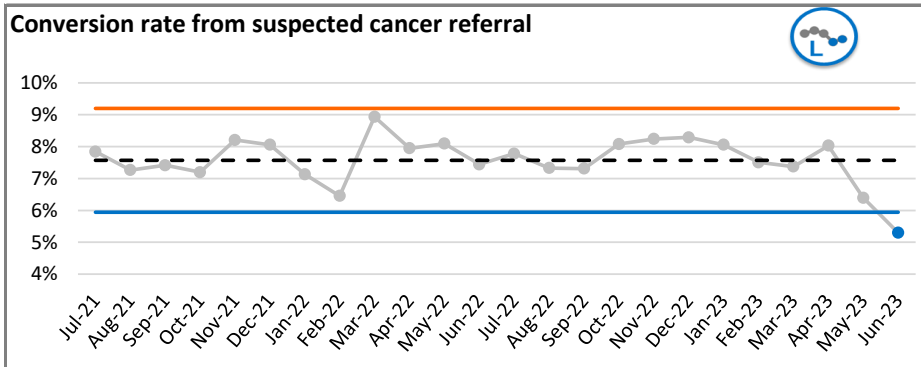
Proportion of cancer PTL waiting more than 62 days



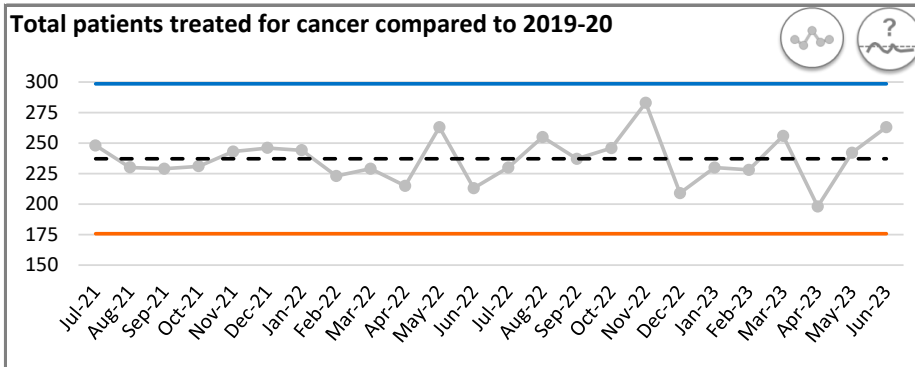
Number of cancer PTL waiting more than 104 days



Conversion rate from suspected cancer referral



Total patients treated for cancer compared to 2019-20



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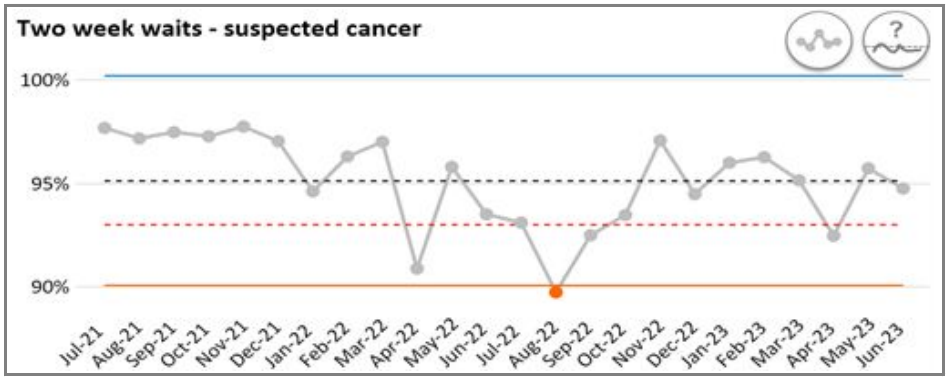
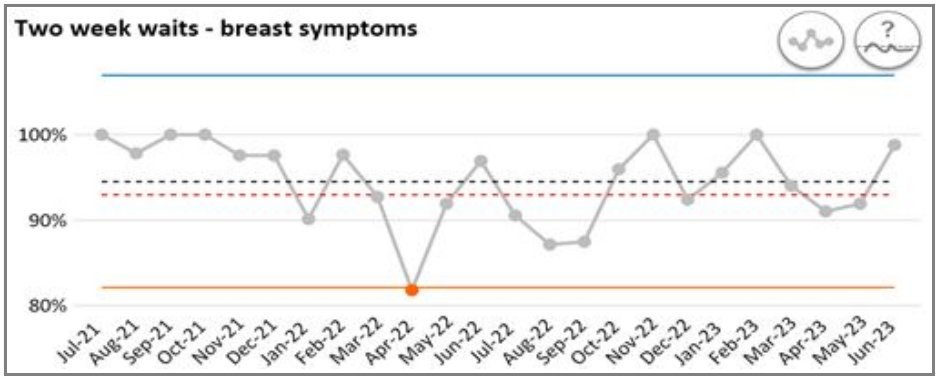
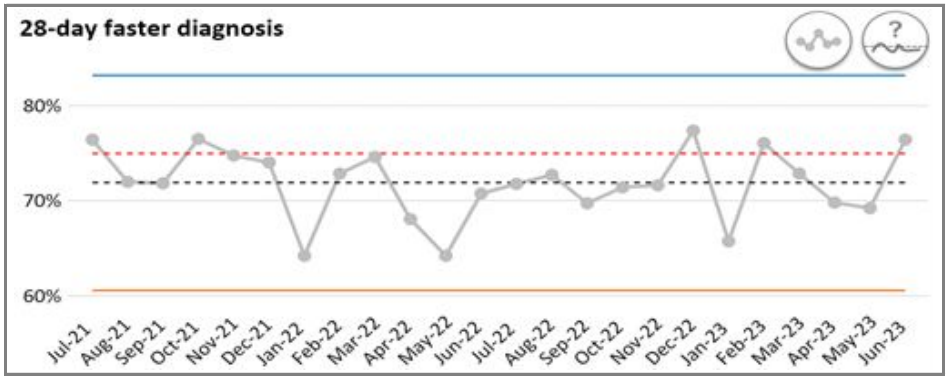
Operations

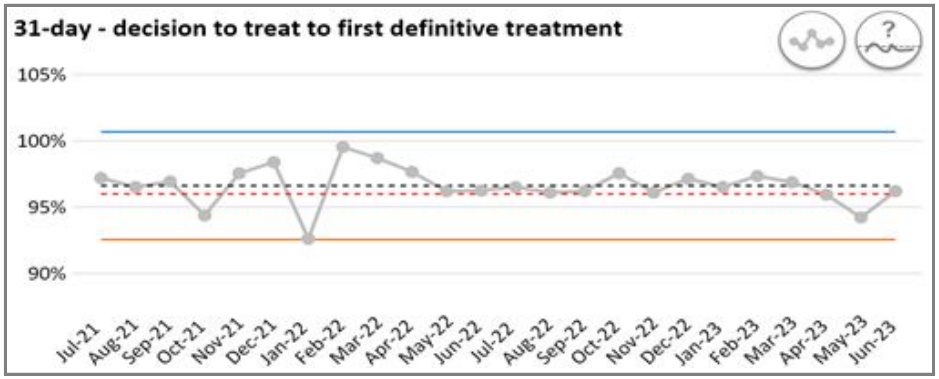
Cancer Waiting Times

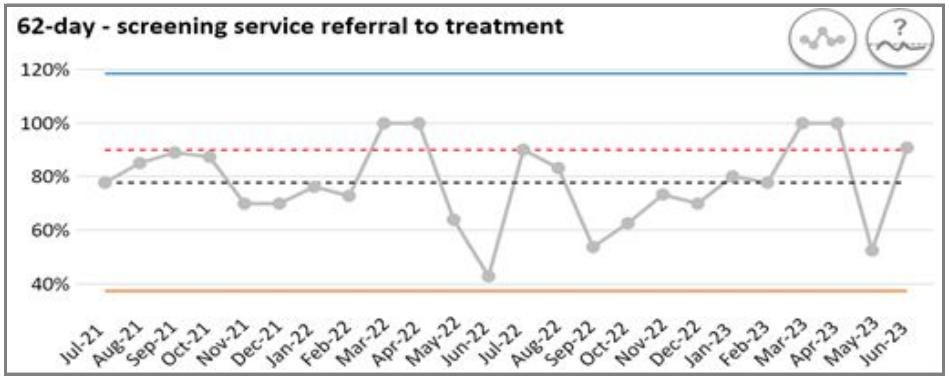
East and North Hertfordshire NHS Trust











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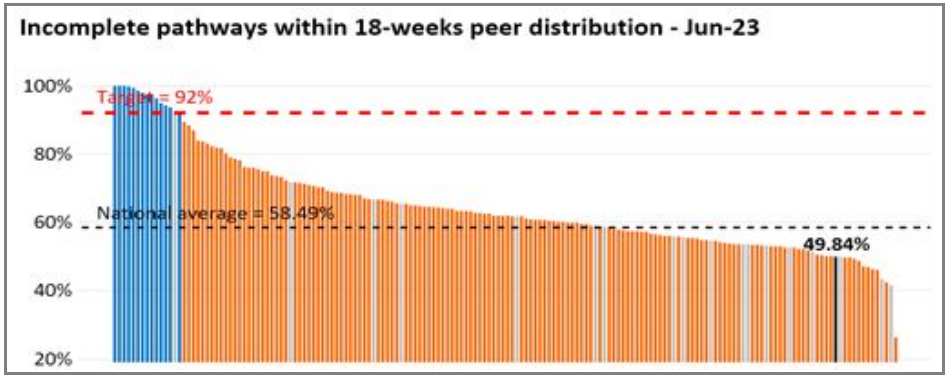
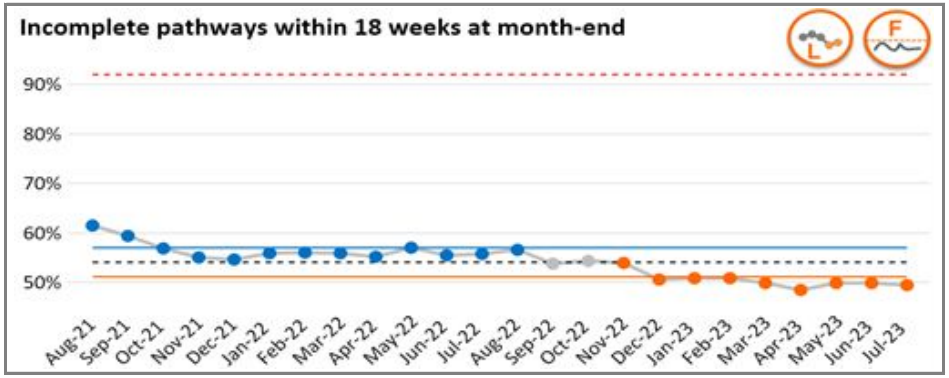
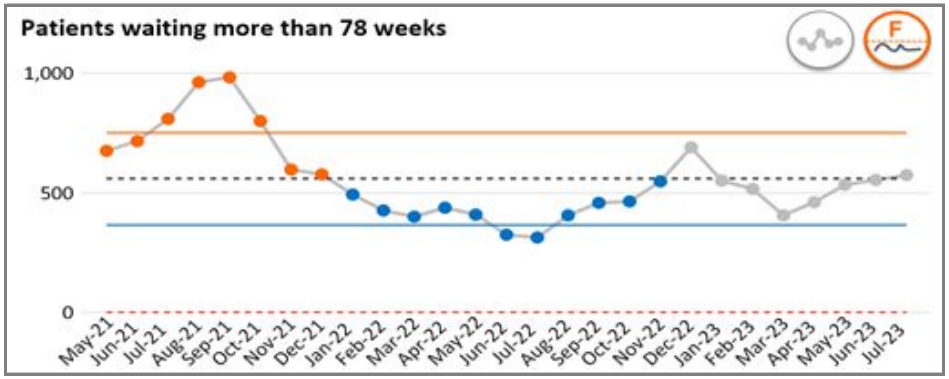
Operations

RTT 18 Weeks

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

RTT Performance

- 78+ week waiters: The Trust had 573 patients waiting over 78 weeks at the end of July, compared to 553 the previous month. This was due to an increase of 29 patients in Community Paediatrics.
- The majority of the breaches were known capacity issues in Community Paediatrics (540) and Trauma and Orthopaedics (23), or patient choice and complexity delays.
- The number of patients waiting 78+ weeks for an appointment was 0.9% of total RTT PTL.
- 104+ week waiters: There was 1 patient waiting 104 weeks at the end of July caused by a pop on 31/7. The patient has now chosen to delay their treatment after their Pre Assessment appointment.
- The Trust had 1,650 patients waiting over 65 weeks for first definitive treatment at the end of July (1,216 were for Community Paediatrics).

Data Quality

- Patient pathways over 12 weeks with identified data quality issues are validated and updated every 12 weeks where possible.
- All patients waiting 65 weeks+ are actively managed with the services.

Activity

- Admitted and non admitted clock stops have decreased in month.
- Number of episodes moved to PIFU pathway continues to increase.
- New and Follow-up attendances decreased in month.
- Elective Day Case and Inpatient activity decreased.
- Theatre utilisation has increased.
- Number of outpatient attendances per clinic increased in month.
- DNA rate has reduced to below the lower control limit.

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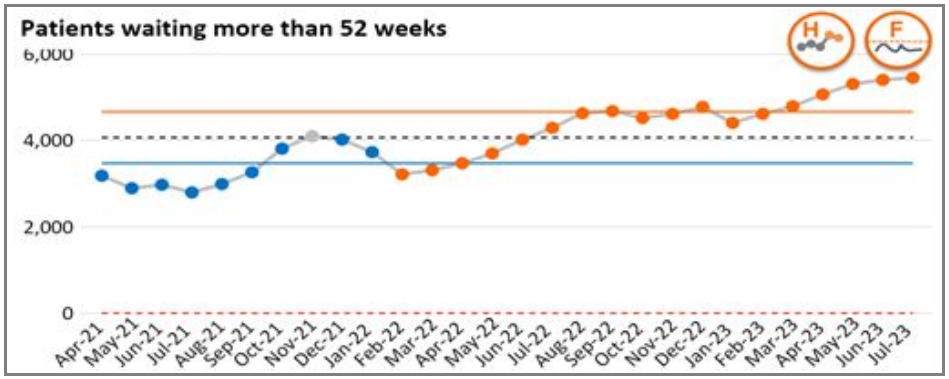
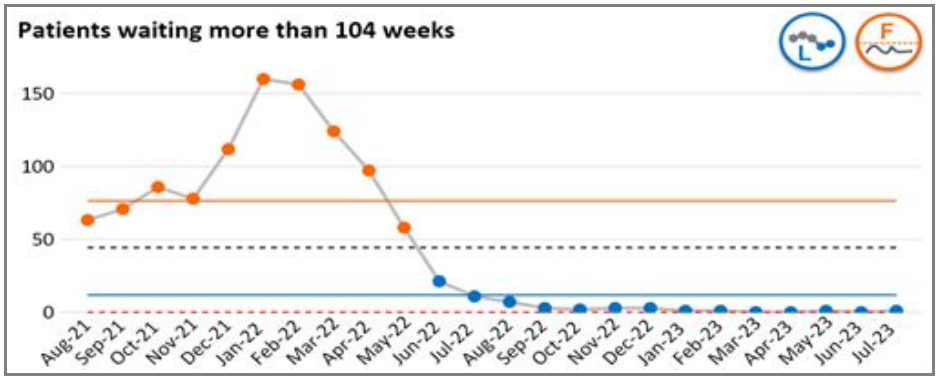
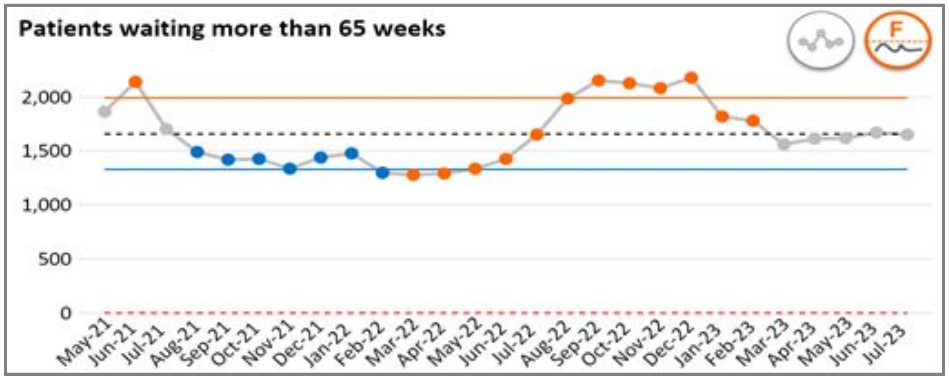
Operations

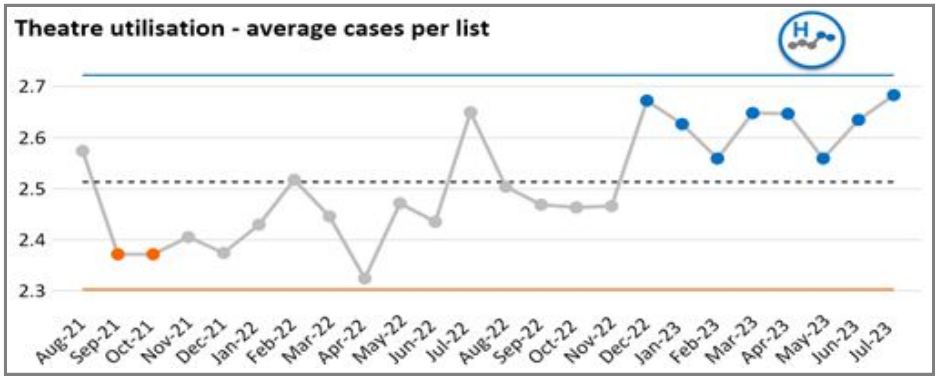
RTT 18 Weeks Supporting Metrics

East and North Hertfordshire NHS Trust









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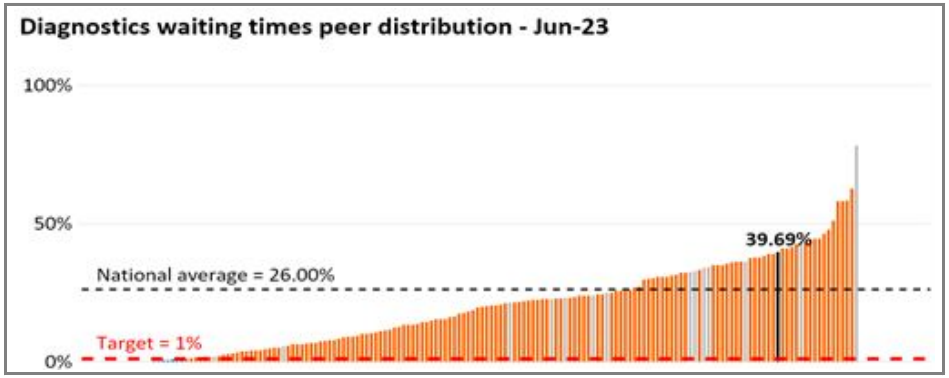
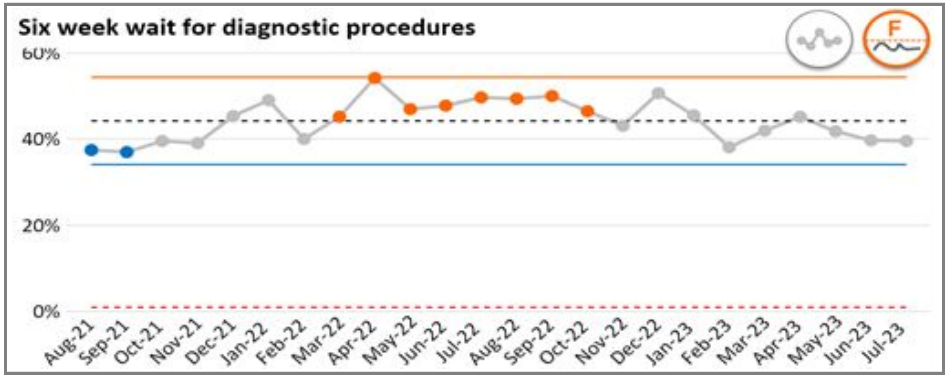
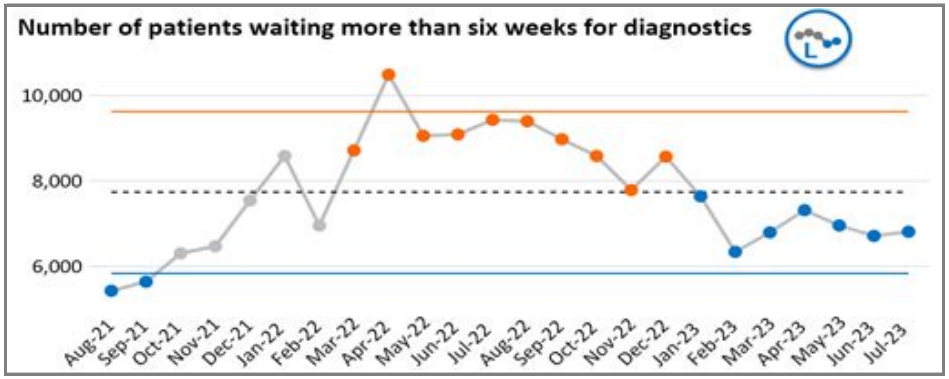
Operations

Diagnostics Waiting Times

East and North Hertfordshire NHS Trust







Key Issues and Executive Response

Improvements

- Overall demand in July (12,622) is 4.6% lower compared with June (13,244) demand (events).
- 80.4% of the demand (10,143) were completed in month, compared with 79.5% in June.
- Community Diagnostic Centre (CDC) activity continues to meet trajectory, except for DEXA with positive patient feedback.
- Robust vetting process within Gastroenterology.
- Cardiology CDC is live and echo capacity increased to support compliance by end of September

Challenges

- CT1 is near end of life, and breakdown rate has increased. This is currently mitigated by CT4 although there are still safety equipment that need to be put in place (alarm).
- Continued sustained increase in cancer demand for CT, MRI & US, impacting ability to regain compliance.
- Significant increase in 2ww demand
- Delay in opening 6th endoscopy room due to nursing establishment. Pushed back to September
- Endoscopy paper referral process increasing inefficiencies and risks.
- 2 x WTE Vacancies within Endoscopy waiting list officers impacting booking and efficiencies
- Waiting time for new ECHO referrals is approx. 11wks. Increase in urgent referral demand, which is taking up routine capacity.

Actions

- Complete CT4 snagging to be fully operational.
- ECHO: Recruitment plan in place, with aim to have appropriate staffing model from October to enable implementation of 7 day working and increased capacity from November.
- Gastro consultants triage clinics to be implemented to manage demand of referrals within Gastroenterology
- Ongoing management of Endoscopy waiting times to meet DMO1 trajectory by end of March 2024.

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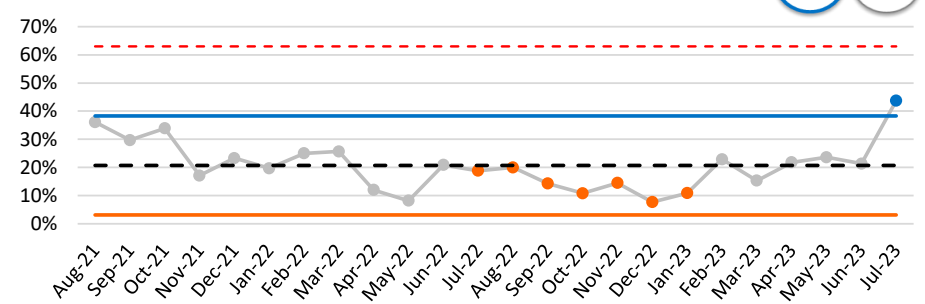
Operations

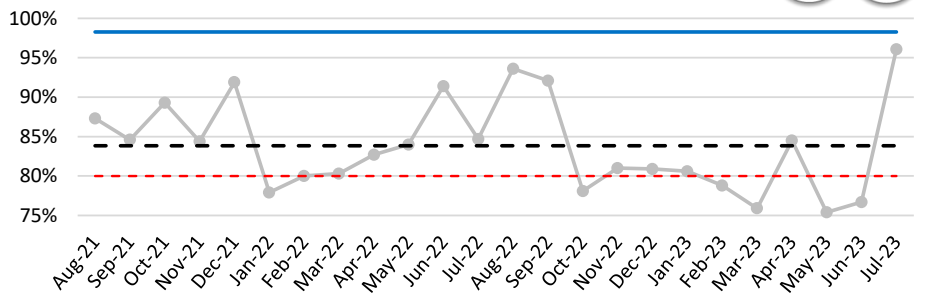
Stroke Services Supporting Metrics

East and North Hertfordshire NHS Trust

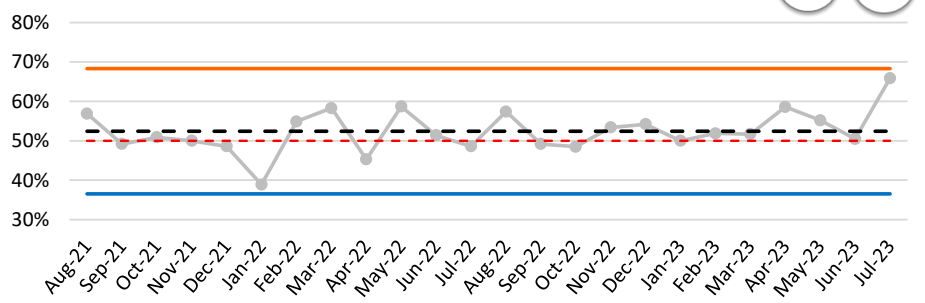
4-hours direct to Stroke unit from ED



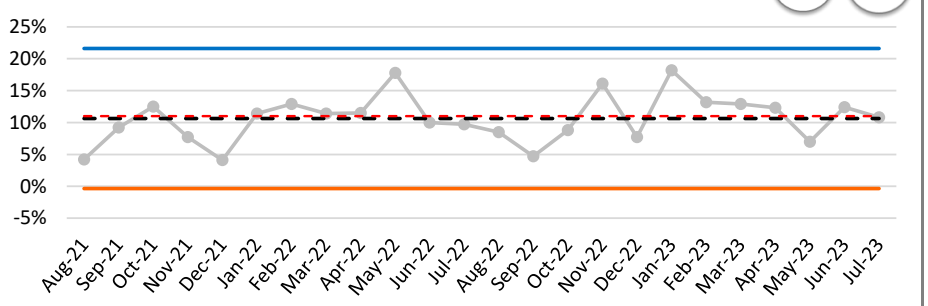
If applicable at least 90% of patients' stay is spent on a stroke unit



Urgent brain imaging within 60-mins for suspected acute stroke



% of all stroke patients who receive thrombolysis



Key Issues and Executive Response

- Ongoing improvement seen for July 23 - across 8 out of 10 Domain.
- Adherence to the '4hr direct to stroke unit' standard is a ongoing challenge. Improvement in month performance, twice weekly huddles to review non achievement pathways as a system and take learning to support ongoing improvements.
- Out of hours medical clerking has been strengthened with allocated support from the medical on call team. Review of out of hours breaches for focused audit, for review of the Stroke service requirements to reduce the breaches out of hours -
- Bid for Video Triage pilot submitted in conjunction with EEAST, awaiting outcome. Evidence has seen a significant improvement in response times for Thrombolysis pathways.
- Specific roles have been implemented to improve the thrombolysis pathway across ED and Stroke - Audit underway to review compliance.
- Physiotherapy and Occupational Therapy have increased service provision - but challenges as this still doesn't provide 7 day service only 6 day, due to establishment review aligned to New Clinical Guidelines.

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Finance

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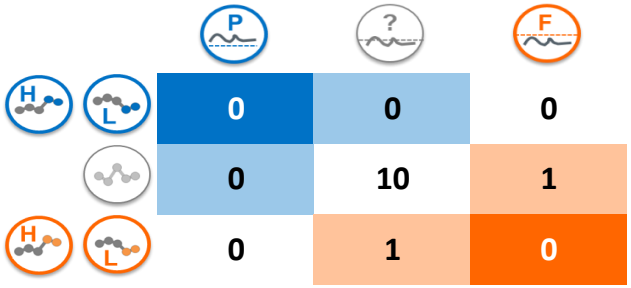

Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Summary Financial Position	Surplus / deficit	Jul-23	-2.4	-0.69			Common cause variation Metric will inconsistently pass and fail the target
	CIPS achieved	Jul-23	1,245	3,743			One point above the upper process limit No target
	Cash balance	Jul-23	77.9	64.7			Common cause variation Metric will inconsistently pass and fail the target
Key Financial Drivers	Income earned	Jul-23	45.3	51.3			Common cause variation Metric will inconsistently pass and fail the target
	Pay costs	Jul-23	29.5	32.0			Common cause variation Metric will inconsistently pass and fail the target
	Non-pay costs (including financing)	Jul-23	15.5	19.9			Common cause variation Metric will inconsistently pass and fail the target

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Finance

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Key Payroll Metrics	Substantive pay costs	Jul-23	24.9	28.2		?	Common cause variation Metric will inconsistently pass and fail the target
	Average monthly substantive pay costs (000s)	Jul-23	0.9	4.8		F	Common cause variation Metric will consistently fail the target
	Agency costs	Jul-23		1.0			Common cause variation No target
	Unit cost of agency staff	Jul-23		10.9			Common cause variation No target
	Bank costs	Jul-23	3.7	2.9		?	Common cause variation Metric will inconsistently pass and fail the target
	Overtime and WLI costs	Jul-23	0.5	0.8	H	?	2 points above the upper process limit Metric will inconsistently pass and fail the target
Other Financial Metrics	Elective Recovery Fund income earned	May-23	1.1	0.5		?	Common cause variation Metric will inconsistently pass and fail the target
	Drugs and consumable spend	Jul-23	2.8	3.3		?	Common cause variation Metric will inconsistently pass and fail the target
	Private patients income earned	Jul-23	0.4	0.4		?	Common cause variation Metric will inconsistently pass and fail the target

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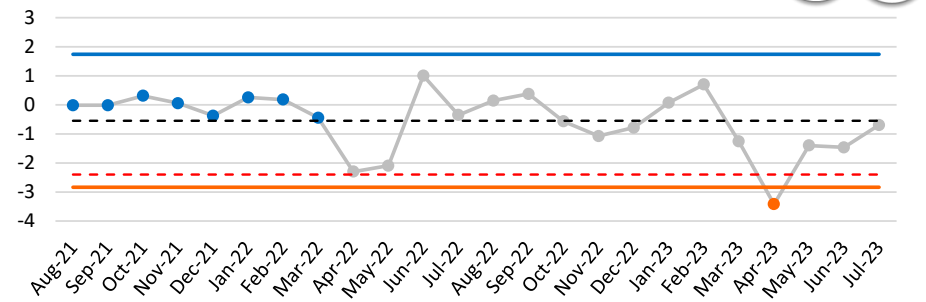
Finance

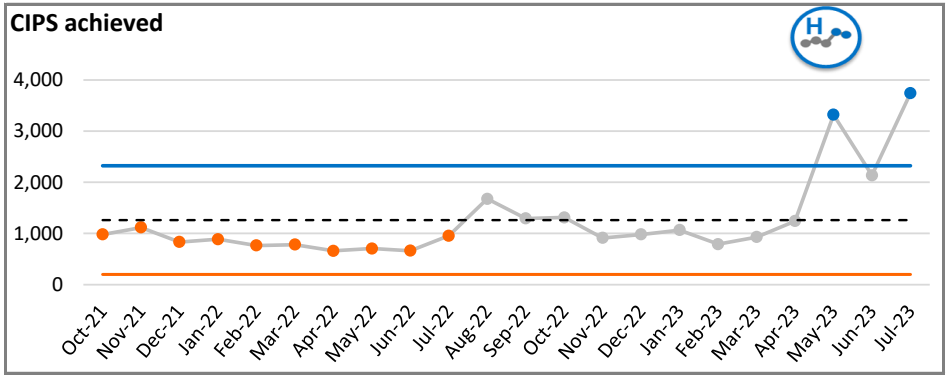
Summary Financial Position

East and North Hertfordshire NHS Trust

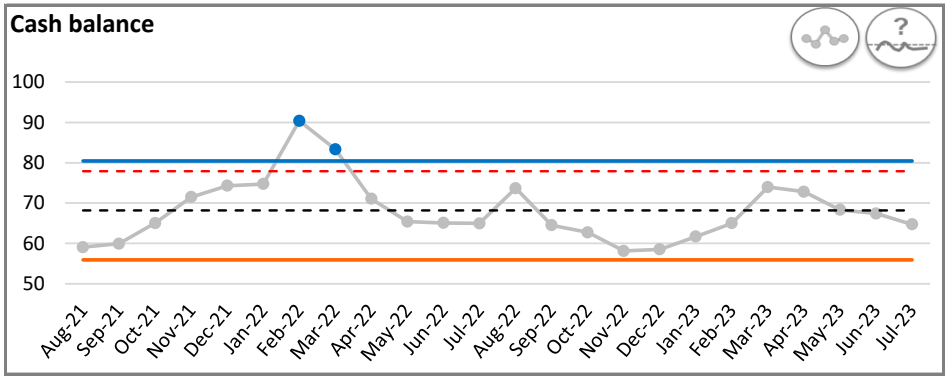
Surplus / deficit



CIPS achieved



Cash balance



Key Issues and Executive Response

- The Trust submitted a final 23/24 plan in May of £2.5m deficit. This plan assumes that a £33.1m cost improvement programme will be delivered.
- At Month 4, the Trust had planned for a YTD deficit of £6.6m and reported an actual YTD deficit of £7.0m.
- The financial impact of industrial action of the Trust during Q1 has been significant, resulting in net extra pay costs of £568k and lost activity valued at £2,584k. As directed ERF income has been matched to plan.
- Pay budgets report a YTD overspend of £1.0.m. A number of hotspots of concern have emerged in respect of management of CSW budgets and elements of medical staffing spend.
- The CIP target for the YTD is £9.2m, against which savings of £10.4m have been recorded. Concern remains in respect of the level of unidentified savings plans within the Unplanned Division.

	Annual Budget £m	Budget YTD £m	Actual YTD £m	Variance YTD £m
Income	607.8	198.4	199.2	**0.8**
Pay	-376.5	-126.9	-127.9	**-1.0**
Non Pay	-199.6	-66.6	-68.0	**-1.3**
EBITDA	**31.7**	**4.8**	**3.3**	**-1.5**
Financing Costs	-34.2	-11.4	-10.3	**1.1**
Surplus / Deficit (excl Fin Adj's)	**-2.5**	**-6.6**	**-7.0**	**-0.4**
Adj Financial Performance	-0.3	-0.1	-0.1	**0.0**
Deficit (Incl Fin Adj's)	**-2.8**	**-6.6**	**-7.1**	**-0.4**

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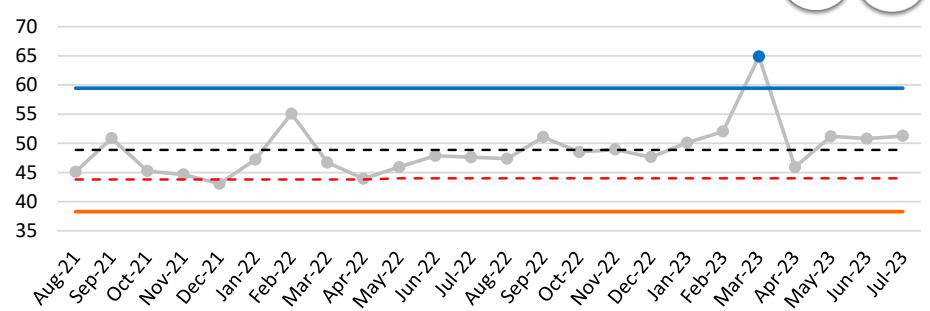
Finance

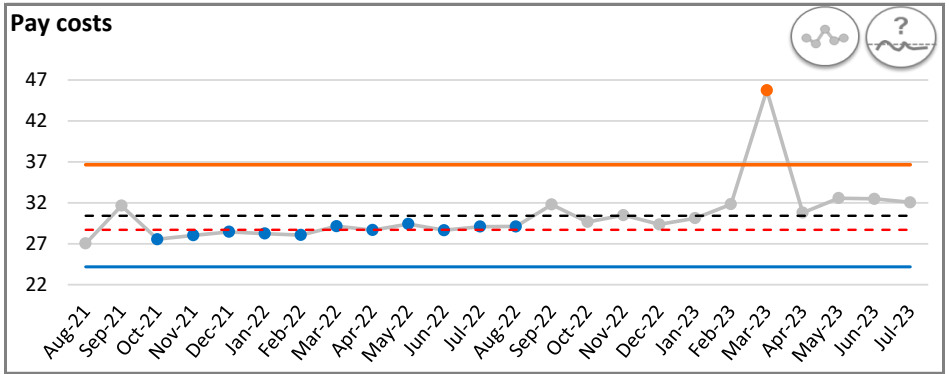
Key Financial Drivers

East and North Hertfordshire NHS Trust

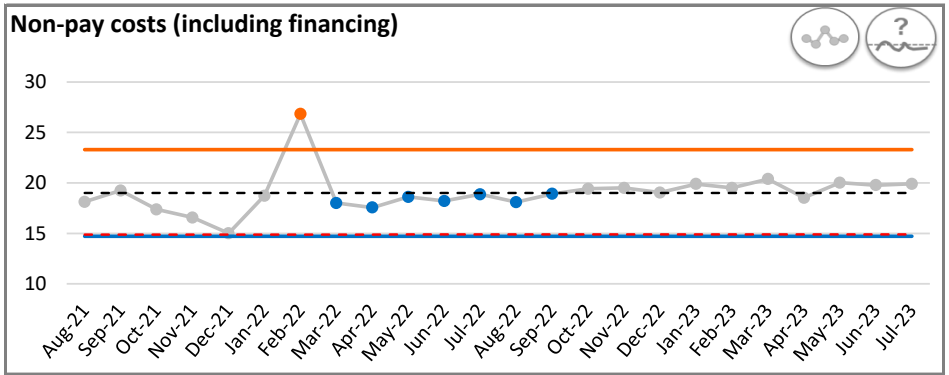
Income earned



Pay costs



Non-pay costs (including financing)



Key Issues and Executive Response

- The Trust submitted a final 23/24 plan in May of £2.5m deficit. This plan assumes that a £33.1m cost improvement programme will be delivered, supported by some release of non recurrent support.
- Plan phasing recognised a graduated start to the CIP programme, as well as a profile for stepping up of elective activity / ERF income. In the second half of the financial year the Trust is required to deliver monthly surpluses.
- At Month 4 YTD, the Trust planned for a deficit of £6.6m and the actual deficit was £7.1m.
- National guidance for M4 is that no provider should show any variance against the external plan for elective recovery. This is mainly due to the uncertainty regarding the industrial action. The reported position includes a £0.9m income provision, so that there is no variance from ERF plan.
- The reported position includes the expenditure impact of the 2nd industrial action this financial years. Additional costs of £0.2m were incurred in month, and there is a £0.6m expenditure impact year to date
- Income was £0.4m favourable to plan in month (£0.8m favourable YTD), due mainly to high cost drugs income, which is offset by non pay spend.
- Medical staff was £0.5m adverse in month excluding the impact of industrial action. There continues to be some significant 'hotspots' within Womens services, Childrens services, Microbiology and Orthopaedics, which are collectively £0.3m adverse in month. Task and finish groups, comprising medical, operational, workforce and finance colleagues, have been set up to undertake deep dive reviews into the drivers of the variances and to agree mitigations.
- The overspend against Clinical Support Worker budgets totals £796k in the YTD. The Trust has successfully recruited additional permanent CSW's over recent months but has been unable to manage down bank spend.
- The Trust has a challenging CIP target of £33.1m this year. The year to date CIP performance is favourable against plan, however the plan significantly increases in the second half of the year. The Trust has been working with ICB colleagues to agree and implement a deficit control framework, as the system is significantly off plan in the first four months of the year. This is expected to increase without a robust framework to reduce expenditure and improve productivity across the system.

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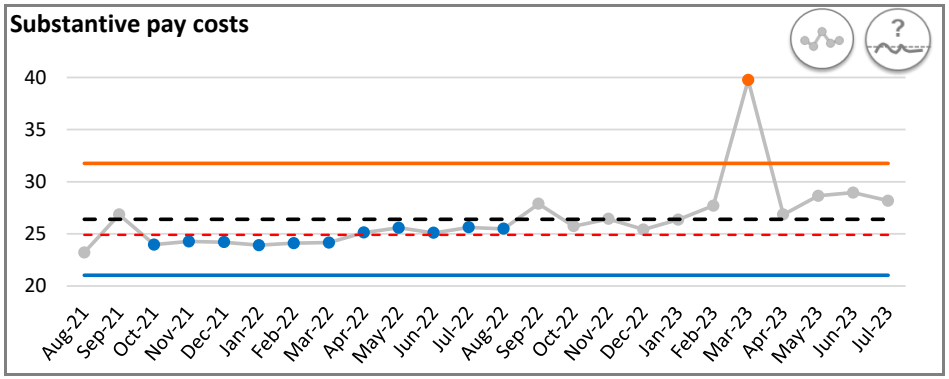
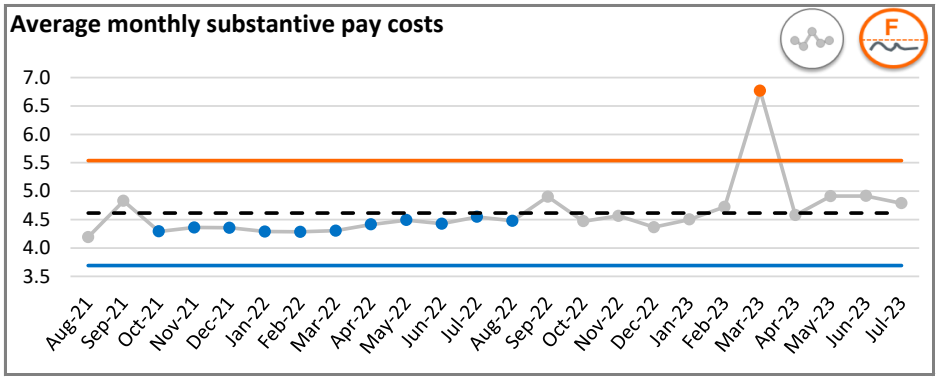
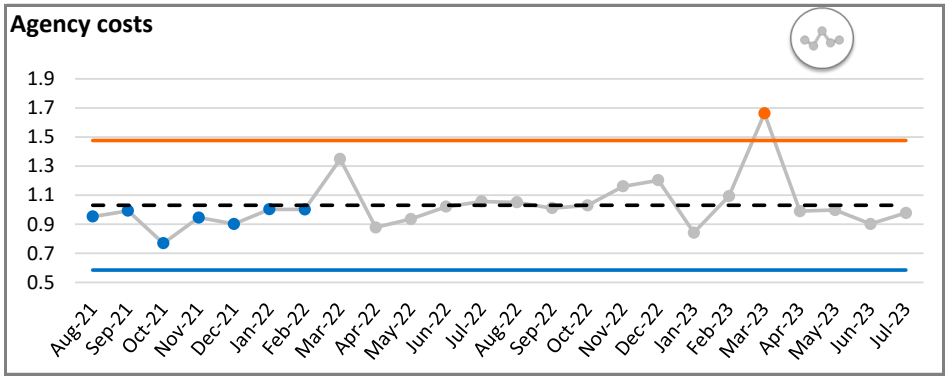
Finance

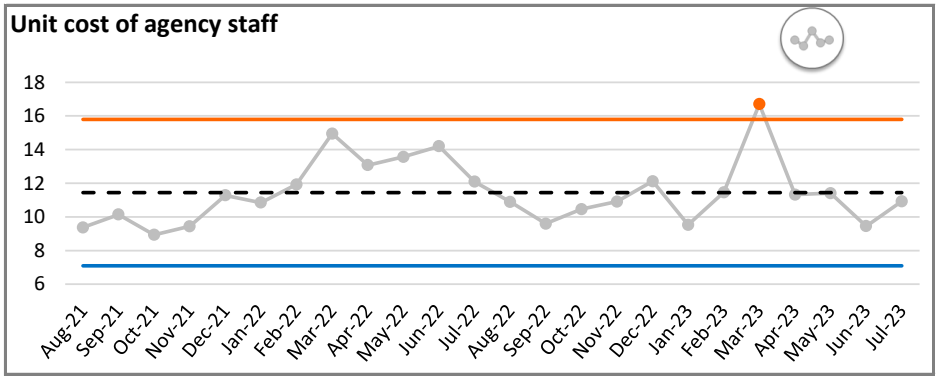
Other Financial Indicators

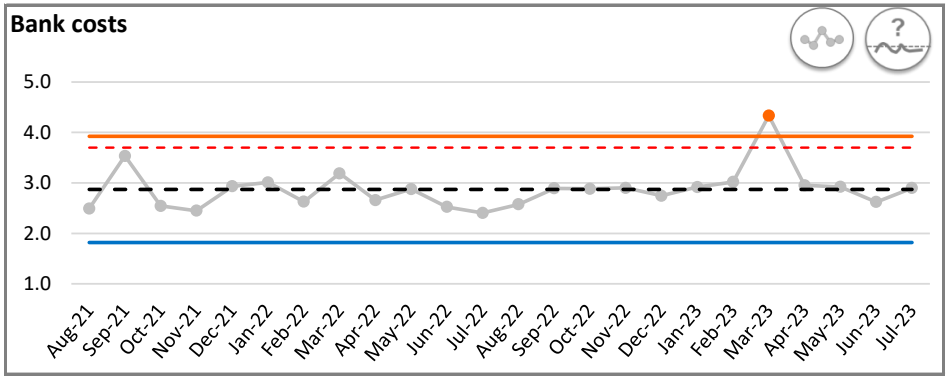
East and North Hertfordshire NHS Trust

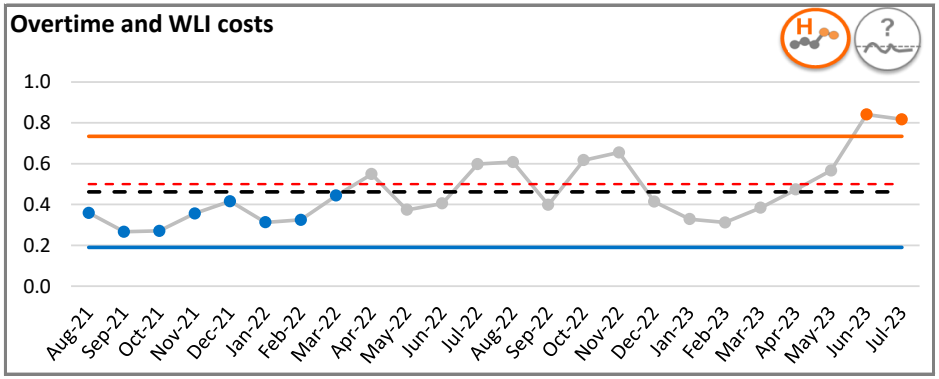












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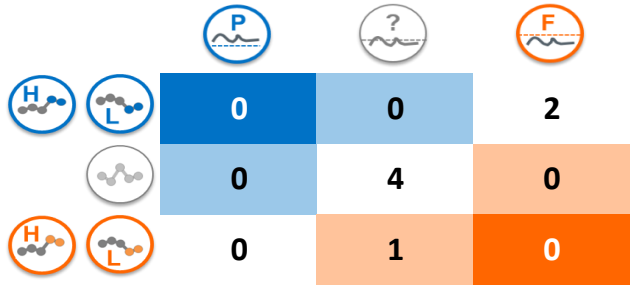
East and North Hertfordshire NHS Trust

People

Month 04 | 2023-24



People

Summary

East and North Hertfordshire NHS Trust

Domain	Metric	Period	Target	Actual	Variance	Assurance	Comment
Work	Vacancy rate	Jul-23	5%	7.4%	H	?	11 points above the mean Metric will inconsistently pass and fail the target
	Bank spend as a proportion of WTE	Jul-23	5%	9.3%		?	Common cause variation Metric will inconsistently pass and fail the target
	Agency spend as a proportion of WTE	Jul-23	3%	3.3%		?	Common cause variation Metric will inconsistently pass and fail the target
Grow	Statutory and mandatory training compliance rate	Jul-23	90%	89.4%	H	F	One point above the upper process limit Metric will consistently fail the target
	Appraisal rate	Jul-23	90%	70.2%	H	F	7 points above the upper process limit Metric will consistently fail the target
Thrive	Turnover rate	Jul-23	11%	11.5%		?	Common cause variation Metric will inconsistently pass and fail the target
Care	Sickness rate	Jul-23	3.8%	4.3%		?	Common cause variation Metric will inconsistently pass and fail the target

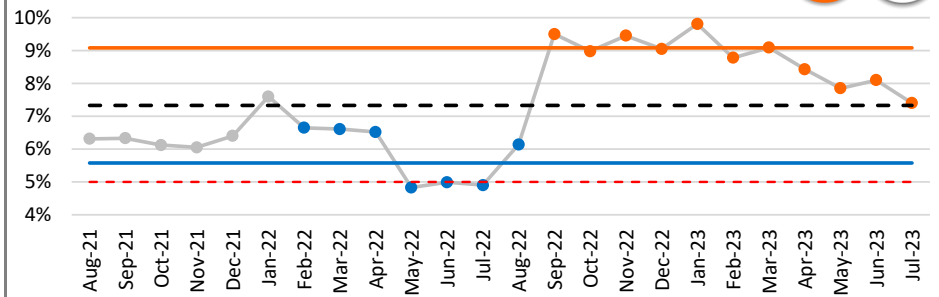
Month 04 | 2023-24

People

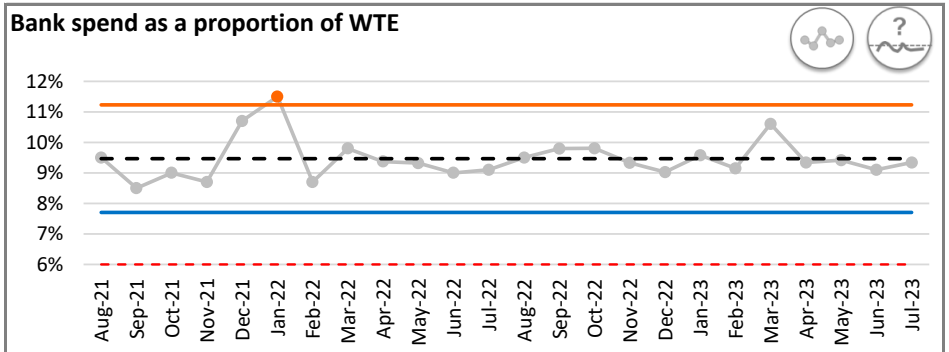
Work Together

East and North Hertfordshire NHS Trust

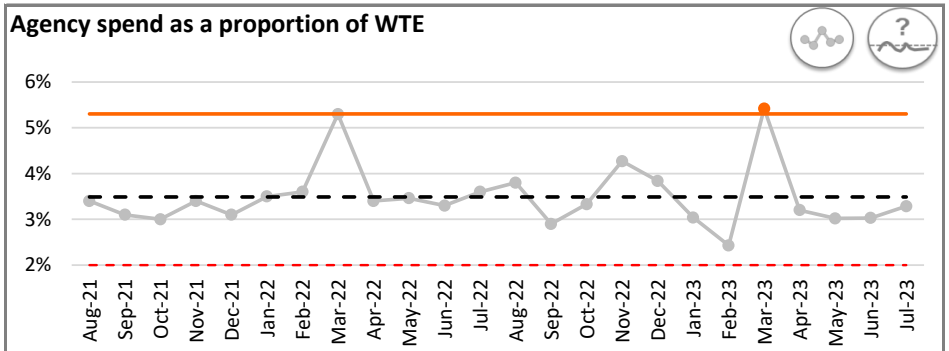
Vacancy rate



Bank spend as a proportion of WTE



Agency spend as a proportion of WTE



Key Issues and Executive Response

- Recruitable establishment increased by 10 WTE however the overall vacancy rate reduced to 7.4% (487 vacancies) in M4, there are 165 more staff in post than July 2022. Overall, the trust remains 2.4% above vacancy target.
- Nursing & Midwifery vacancy rate increased to 9.3% (190 vacancies) primarily due to 30 WTE fewer staff in post vs M3. As vacancies reduce, a targeted approach towards UK based nurses is underway to balance skill-mix. A targeted campaign and talent pool is being piloted to ensure an ongoing pipeline. There are 47 more nurses/midwives in post than 12 months ago.
- 67 student nurses have been offered Band 5 roles within the Trust when they qualify later in the year (against a target of 50)
- There are 18 student midwives in the pipeline (starting in M6) and 3 midwives who were recruited as a result of the recent maternity open day. Overall, there are 271 applicants in the pipeline including 37 doctors, 91 nurses/midwives, 36 clinical support workers and 32 allied health professionals.
- 311 junior doctors processed for August rotation alongside 140 junior doctors leavers processed - work is underway to process the further 64 doctors for the September rotation.
- Agency spend was 58k under M4 NHSI agency ceiling target. Improvement in 'Great for 8%' temporary staffing playbill reducing to 11.8% (from 13.3% in M1), proactive actions remain underway between Resourcing, Temporary Staffing and Finance triangulation to improve metrics, full update on progress to be shared with Executive Programme Board (EPB) on 17/08.
- Interface is now live between ESR and ENH Academy - updating competencies only and will mean that the Trust will be able to use ESR to report on competencies and training compliance going forward.

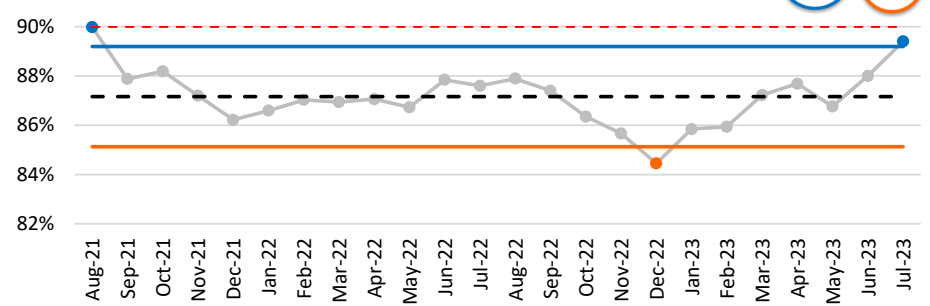
Month 04 | 2023-24

People

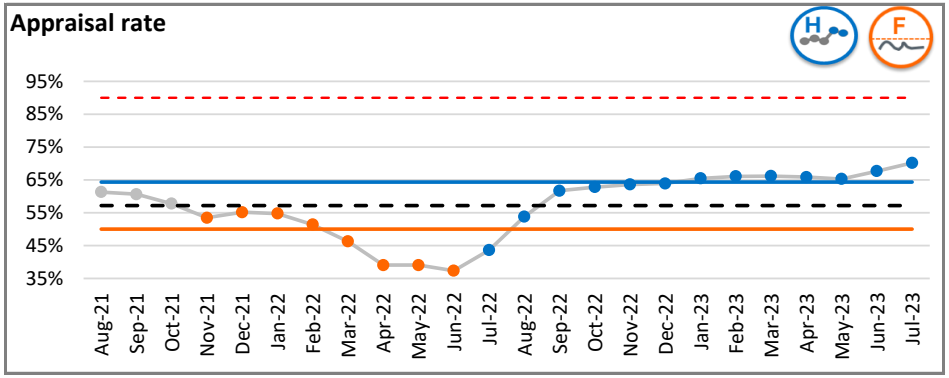
Grow Together

East and North Hertfordshire NHS Trust

Statutory and mandatory training compliance rate



Appraisal rate



Key Issues and Executive Response

- Grow Together review compliance is increasing steadily currently at 69.8%, a 2.1% increase on previous month. Weekly Trust News reminders, will take place in the last month of this year's window, followed up with direct emails to service leads.
- Feedback surveys are now completed at the end of each grow together review meeting, providing real time feedback on improvements required, in readiness for the new window opening in April 2024.
- Mandatory training has shown an increase in July to 89.4%, the highest figure achieved over the preceding 12 months. Improvements are also driven by the need for staff to be 100% compliant for a successful grow together review as well as targeted emails to non-compliant staff and teams.
- Additional rooms are being sourced to support the delivery of face-to-face training sessions such as Resuscitation and Moving and handling. This includes identifying space internally, as well as externally with local organisations such as North Herts college. The recent upgrade of the Trust simulation Bed (Linet Bed) at the LEC has supported with increasing capacity for training e.g. increasing the numbers of new Junior doctors trained on moving and handling techniques.
- Improvements in the Trust induction and onboarding process for new staff has also allowed for early access to ENH Academy, with new starter uploads from ESR to ENH Academy increasing from twice weekly to daily.
- Better connectivity between people and digital teams, now ensures new starter ESR email updates occur more frequently on ESR, which enables prompter creation of ENH Academy accounts. Better connectivity between other teams is in progress such as with Estates for early carparking access.

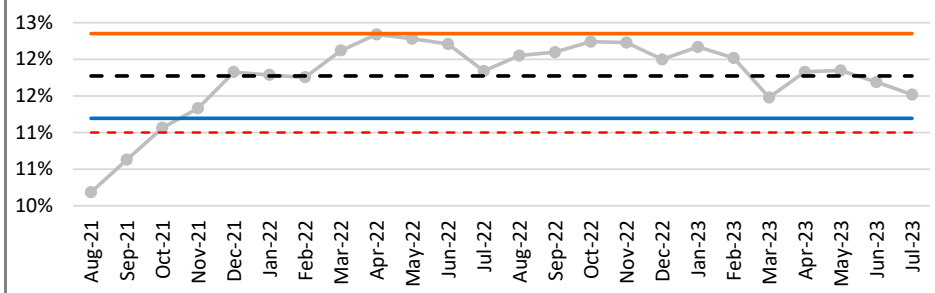
Month 04 | 2023-24

People

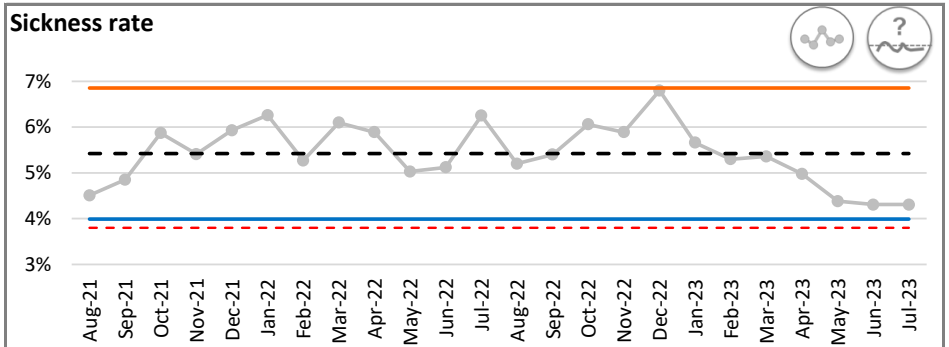
Thrive Together | Care Together

East and North Hertfordshire NHS Trust

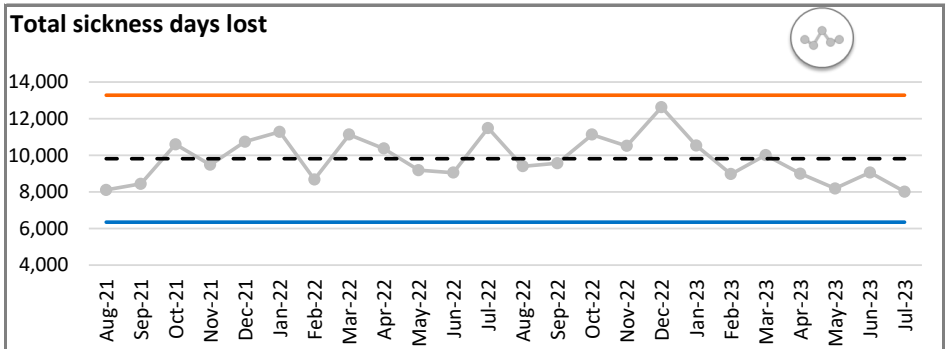
Turnover rate



Sickness rate



Total sickness days lost



Key Issues and Executive Response

Thrive Together

- Pulse survey shows improvements in Relative likelihood of white applicant being shortlisted and appointed for BAME and disabled applicant scores EDI strategy in development and due to People Committee in November 2023
- Preparation for this years EDS2 work and decisions on medical areas to select to review underway and will conclude in September to improve engagement for this years assessment
- A number of formal employee relations cases are at hearing stage and will effect the time open durations of cases and average days of suspensions
- Work to systematically review all nursing secondments well underway to bring in line with new policy and mitigate risks to the Trust, wider work across ENHT running alongside
- Work continues on preparation for 2023 staff survey launch in September

Care Together

- 0.5% Improvement in people pulse results in Safety culture theme score and 2.3% improvement in perception of leadership culture, bullying and harassment score increasing showing staff are telling us more about this happening
- The summer clothes and toys shop opened in August donations were received from staff and staff could collect items and browse in the staff community shop
- Final plans coming together for this years flu vaccination programme and identify the vaccine hub, which will open from early October 23

Month 04 | 2023-24

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	14.1
Report title	Maternity Assurance	**Meeting Date**	6 September 2023
Presenter	Amanda Rowley – Director of Midwifery		
Author	Amanda Rowley, Director of Midwifery Maria Williams, Risk and Governance Co-ordinator		
Responsible Director	Amanda Rowley - Director of Midwifery	**Approval Date**	29 August 2023

Purpose *(tick one box only)*	**To Note**	☐	**Approval**	☐
	Discussion	☒	**Decision**	☐

Report Summary:

Maternity and Neonatal services are required to provide assurance to Trust Board based on a number of core data sets in response to national reviews, the ambition of maternity transformation and to meet the requirements of NHS Resolutions (NHSR) in meeting the requirements of the clinical negligence scheme for Trusts (CNST). Year 5 of the scheme commenced on 30 May 2023. Assurance is provided through inclusion of the maternity dashboard and the perinatal clinical quality surveillance framework report.

NHSR stipulates that the Trust Board receive a bi-annual midwifery staffing oversight report. The previous report was received and noted by the board in January 2023. The Midwifery workforce Report included meets the evidential requirements set out in CNST year 5 and demonstrates the midwifery workforce position against the last birth-rate plus establishment review recommendations from November 2021.The report notes that the outcome of a refreshed establishment review is expected in September that will make a revised recommendation based on current birth-rate and levels of acuity.

The report notes the work ongoing in the service to strengthen leadership and culture using the Health Teams Framework.

Impact: where significant implication(s) need highlighting

NHS Resolution is operating year five of the CNST Maternity Incentive Scheme to deliver a safer maternity service. The scheme incentivises ten maternity safety actions. If trusts achieve all of the ten safety actions, they will recover their contribution relating to the CNST maternity incentive fund as well as a share of any unallocated funds.
ENHT was compliant with 8/10 Safety Actions in Year 4.

Risk: *Please specify any links to the BAF or Risk Register*

Risk of non-compliance with Y5 MIS due to lack of staffing resource with the maternity and neonatal safety and quality team (ID 3070).
Risk of insufficient midwifery staffing levels due to current vacancy and absence could impact the safety and experience of service users (ID 70)
The current model of staffing maternity theatres and recovery with midwives does not meet AFPP standards and reduces the availability of midwives to undertake midwife only tasks (ID 1140)

There is a reputational risk in relation to the CQC Safety Notice and Maternity Survey findings that could result in the loss of confidence in the service for staff and service users (ID 3069).	
Report previously considered by & date(s):	
N/A.	
Recommendation	**Trust Board are requested to:** • **Accept and formally minute receipt for the Midwifery workforce Report for July 2023 as stipulated within CNST year 5.** • **To note and formally minute the assurance provided to, and approved by, the quality and safety committee that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool). The quarterly bereavement Report was reviewed and approved by Quality and Safety Committee in July 2023 as per the minimum evidential requirements set out in safety action 1 of CNST yr. 5.** • **To note the contents of the maternity and neonatal assurance Report**

To be trusted to provide consistently outstanding care and exemplary service

Division - Women's Services

East and North Hertfordshire NHS Trust

Maternity Assurance Report

Trust Board: 6 September 2023

Amanda Rowley, Director of Midwifery

Executive Summary

East and North Hertfordshire NHS Trust

Midwifery workforce:
A midwifery establishment review using birth-rate plus methodology has just been undertaken at ENHT and the final report is expected in early September. This will make a recommendation of staffing based on number of births over the last 12 months and current acuity related to rise in LSCS and induction of labour rates. The establishment review will exclude maternity theatres and recovery recognising that this needs its own nursing staffing model. The breakdown of the last birth-rate plus review undertaken in November 2021 is included within this report including the variance against our current budgeted and worked establishment as of month four. Work to support positive culture and behaviours continues to be embedded across the service

CQC update:
Following the inspections on the 4th and 5th October 2022 and reinspection on the 20th – 22nd June 2023 The divisional leadership team have been working with our Maternity improvement advisors as part of the maternity safety support programme.

The diagnostic phase of the programme is now complete with the report recognising the scale of improvements already made. The report suggested opportunities for further and sustained improvements within three workstreams of systems and processes, Culture and diversity and staffing and leadership. A sustainability action plan is currently under development in response to the report.

CNST:
Safety action 1: The MBRRACE–UK programme of work comprises national surveillance of late fetal losses (22 – 23 weeks' gestation), stillbirths and infant deaths and the provision of confidential enquiries into stillbirths, infant deaths and cases of serious infant morbidity on a rolling basis. The first quarterly report was discussed and accepted by members of the quality and safety committee in July 23 which provided assurance that the maternity services are contemporaneously and continuously monitoring the Stillbirth and Neonatal death rates, by means of the PMRT (perinatal mortality review tool).
Safety action 3. Representatives from maternity and neonates, audit all admissions to the neonatal unit of babies equal to or greater than 37 weeks. An action plan to address these findings has been shared with and approved by the perinatal quadrumvirate. This will be presented to the quality and safety committee for their approval in September.
Safety action 5. The NHS Resolution Maternity Incentive (MIS) stipulates that a bi-annual midwifery staffing oversight report that covers staffing/safety issues must be submitted to the Board every 6 months, during the MIS year five reporting period.

Pre-term births:
The rate of preterm births in July was 8.29% with a rolling annual rate of 7.29% (against an annual target rate of 6%). Further analysis is currently being undertaken to understand any pattens or themes. However, reassuringly, 69% babies were over 34 weeks' gestation and this month's data included 3 sets of twins (carrying an increased risk of preterm birth). Ongoing oversight and assurance is in place through governance of the saving babies lives (v3) working group and governance pathway.

Lucy Letby case:
– Assurance processes / measures within perinatal services.

East and North Hertfordshire NHS Trust

Within the maternity incentive scheme (MIS) year 5 there are requirements to undertake the following in relation to the safety actions (SA's) within this year's MIS:

- Report to QSC/Trust board – neonatal nursing / neonatal medical staffing position (SA4) and training compliance (SA8)
- Review and present the learning from avoidable term admissions in to the neonatal unit (ATAIN) to the quality and safety committee (SA3).
- Utilisation of the perinatal mortality review tool (PMRT) to review all perinatal deaths to the required standard (SA1). This includes Utilisation of the PMRT to undertake multi-disciplinary review for all baby deaths. Reviews also invite parents' perspectives and questions as part of the review.
- All eligible deaths are reported to MBRRACE: mothers and babies: Reducing risk truth audits and confidential enquiries).
- A quarterly bereavement report is submitted to the quality and safety committee (SA1) alongside quarterly reporting through the "learning from deaths report".
- Monthly walkarounds are undertaken across maternity and neonatal services by the board level maternity and neonatal safety champions to hear any concerns from staff and enable ward to board reporting (SA9).
- 100% of qualifying cases (maternity and neonatal) must be reported to HSIB (Healthcare safety Investigation Branch) and to the NHS Resolutions early notification scheme to achieve compliance with SA10.
- All neonatal outcomes are reported through the divisional, Trust and LMNS governance structure via the monthly maternity dashboard with thematic reviews and outcome data presented at the women's and neonatal quality and safety committee and the local maternity and neonatal system (LMNS) serious Incident oversight and scrutiny group.
- The neonatal governance structure includes: a monthly perinatal mortality and morbidity meeting, a monthly neonatal risk management meeting, monthly neonatal risk management meeting and a Neonatal specialty meeting with representation from the parents advisory group.
- The professional nurse advocate role is being introduced into neonatal services to increase support, hear the voices of staff and to offer restorative supervision sessions.

		Updated/ unchanged Goal	Updated/ unchanged Red Flag	Data Source	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Exception Reporting
Scheduled Bookings	No of women EDD 4 months hence (projected births 4 months ahead)	5500(458 to 539)	<458/ >540 per month	CMIS	392 (Dec)	453 (Jan)	357 (Feb)	437 (Mar)	408 (Apr)	463 (May)	402 (June)	420 (July)	425 (Aug)	402 (Sep)	409 (Oct)	412 (Nov)	
Bookings in month	The number of women booked in month	≥5760/480	≤5760/480 or ≥6600/550	CMIS	501	497	500	549	442	537	479	517	406	488	482	463	
Bookings by 9+6 weeks gestation	The gestation at which women booked in month	≥50.5%	<50.5%	CMIS	78.00%	75.05%	72.40%	69.58%	71.50%	61.06%	70.00%	76.25%	67.57%	69.03%	75.20%	74.08%	
Bookings < 12+6 weeks gestation	The gestation at which women booked in moth		<80%	CMIS	90.60%	89.33%	88.40%	89.62%	90.50%	87.07%	89.00%	91.31%	90.09%	90.98%	88.75%	88.76%	
IOL	Total rate	≤34%	>36%	CMIS	32%	31%	33%	32%	32%	37%	29%	33%	33%	35%	32%	36%	
Births (mothers birthing)	Benchmarked to 5500 per annum including home birth	5500(458)	>490	CMIS	406	428	403	413	397	363	335	438	387	417	404	381	
Births (babies born)	Number of babies born in month	No target		CMIS	415	436	406	425	401	367	338	449	394	429	410	387	
Born before arrival (BBA's)	Births not attended by a midwife	<0.2%	>1%	CMiS	0.49%	0.47%	0.50%	1.50%	0.50%	1.10%	1.20%	1.10%	0.50%	0.70%	1.20%	0.00%	
Home births	Percentage of women birthing at home	≥2%	<1%	CMIS	1.72%	2.10%	1.50%	1.90%	2.30%	0.80%	1.20%	1.60%	2.10%	1.50%	1.70%	1.84%	
MLU Births	Benchmarked to 1500 per annum	≥15%	<12.5%	CMIS	2.96%	2.10%	4.70%	5.50%	7.10%	11.00%	15.10%	14.20%	14.20%	14.10%	13.60%	14.20%	
MLU transfer to CLU	Primip	≤ 40% per month	>45% per month	CMIS	15.00%	14.20%	16.00%	26.60%	40.00%	43.70%	24.00%	30.50%	26.50%	33.30%	48.70%	50.00%	Primip transfers and the reasons for transfer were: Inadequate progress 54%/ Analgesia 37%/ Fetal heart abnormalities 9% There have been a larger number of preceptors rotating through MLU during the last couple of months, the introduction of peanut balls and biomechanics will hopefully have a positive impact on the rates of inadequate progress and we will look at training themes and possible workshops for the MLU staff.
MLU transfer to CLU	Multip	≤ 13% per month	>15% per month	CMIS	27.00%	12.50%	0.00%	0.00%	0.00%	7.40%	3.00%	11.90%	10.00%	9.30%	12.20%	5.30%	
Midwife Led Births	Combined homebirth and MLU Births	≥17%	≤13.5% per month	CMIS	4.68%	4.20%	6.20%	7.40%	9.40%	11.80%	16.30%	15.80%	16.30%	15.60%	15.30%	16.04%	
Spontaneous Vaginal Births	Maintain Vaginal Birth rate	≥56.4%	<53%	CMIS	51%	54%	47%	46%	50%	50%	51%	47%	49%	48%	52%	47%	Ongoing impact of a 40.6% LSCS rate
Vaginal births after previous LSCS	Percentage of VBAC of women with a previous caesarean section who had avaginal birth.	59.10%	<50%	CMIS	64.30%	35.29%	80.00%	47.37%	45.00%	63%	45%	62%	42%	63%	50%	42%	Women are counselled and offered choice in their mode of birth
CLU births (including theatres)	All births occuring within the CLU	≤85.5%	>85.50 %	CMIS	95%	95%	93%	91%	91%	87%	82%	83%	83%	83%	83%	83%	

NHS
East and North Hertfordshire NHS Trust

4 | Maternity Dashboard and Exception Reporting

	Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Exception Reporting
Ventouse & Forceps	10%-15%	<8% or >16%	CMIS	11.82 %	10.75 %	13.40 %	10.90 %	9.80%	9.90%	10.10 %	13.21 %	9.80%	10.60 %	9.65%	12.07 %	
CS of Robson category 1 Nulliparous women with singleton cephalic pregnancy at term in spontaneous labour			CMIS	13%	17%	27%	24%	15%	22%	15%	12%	18%	11%	16%	26%	
CS of Robson category 2 Nulliparous women with singleton cephalic pregnancy at term with induced labour or CS before labour			CMIS	49%	45%	50%	54%	50%	41%	55%	63%	57%	55%	52%	54%	
CS of Robson category 5 (Multiparous women with a singleto cephalic pregnancy at term with a previous CS)			CMIS	84%	90%	88%	85%	88%	82%	88%	81%	89%	86%	87%	88%	
Funded midwife/birth ratio with skill mixing Against YTD births	1:29 (from March 14)	>1:33	HOM	1:24	1:24	1:24	1:24	1:22	1:22	1:24	1:24	1:24	1:24	1:24	1:24	
Funded midwife only ratio Against YTD births	1:32	>1:33		1:26	1:26	1:25	1:25	1:23	1:23	1:23	1:24	1:24	1:24	1:24	1:24	
Actual midwife only ratio Against activity in month	1:32	>1:33		1:27	1:31	1:26	1:25	1:24	1:21	1:22	1:26	1:24	1:26	1:26	1:23	
1:1 care in labour excluding BBAs			CMiS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	Birth-rate plus checked for red flags
Midwifery vacancy rate	TBC	TBC		24.59	29.26	19.80	16.52	7.73	9.44	11.57	28.16	28.16	21.90	19.52	24.78	
Weekly hours of CLU Consultant cover	125	<125		125	125	125	125	125	125	125	125	125	125	125	125	
ITU Admissions in Obstetrics	<8 per annum	≥10 per annum	Datix	1	0	2	2	2	0	0	2	0	0	1	0	
Post partum Hysterectomies	<3 per annum	3 per annum	Datix	0	0	0	0	0	0	0	2	0	0	0	0	
Number of cases of meconium aspiration	2 per month	>4 per month	SEND	1	1	1	1	1	0	2	2	1	0	0	0	
Number of cases of hypoxic encephalopathy (Grades 2&3)	1 per month	>2 in 2 months	SEND	0	0	1	0	1	1	0	0	0	0	1	0	
Term admissions to NNU	<6%	≥6%	Badger	10.60 %	5.30%	8.40%	6.60%	5.70%	5.30%	6.40%	4.90%	6.30%	5.90%	4.60%	5.60%	*June data amended to 4.6%*
Maternal deaths (direct)	0	≥1 a year	Datix	0	0	0	0	0	0	0	0	0	0	0	0	
Pre-labour IUDs	14 per annum	>14 per annum	Bereavement M/W	1	1	2	1	2	0	1	1	0	1	0	0	
Intrapartum IUDs	0	>1 a year	Bereavement M/W	0	0	0	0	0	0	0	0	0	0	0	0	
Early Neonatal deaths	1 per month	>1 per month	Bereavement M/W	0	0	0	0	0	0	0	0	0	0	0	0	

	Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Exception Reporting
Number of Sis (to include duty of candour)	≤2/2 months	>6 per annum	Risk Lead	1	0	0	1	1	1	1	0	0	0	1	0	
Cases declared to HSIB for investigation and accepted	≤2/2 months	>6 per annum		1	0	0	0	0	2	0	0	0	0	0	0	
Open datix that are overdue >30 days (awaiting or being reviewed)	TBC	TBC	Datix	68	94	120	80	76	66	13	50	39	55	63	47	
Never events	0	1	Datix	0	0	0	0	0	0	0	0	0	0	0	0	
Massive PPH ≥1500ml MOH:	≤2.9%	>3.0%		2.21%	1.40%	1.70%	1.60%	0.60%	2.10%	2.30%	3.30%	2.10%	2.64%	2.23%	2.89%	
MOH >2000ml	<2%	≥2.5%	CMIS	1.23%	0.94%	0.50%	1.21%	0.50%	1.10%	1.19%	1.83%	0.78%	1.44%	1.49%	1.58%	
3rd/4th degree tears	<3.5%	≥ 5%	Risk Lead	1.20%	1.60%	4.40%	1.80%	3.50%	1.00%	4.60%	2.70%	1.40%	2.80%	1.20%	1.80%	
3rd/4th degree tears (sustained at instrumental birth)	6.80%	NA		2.20%	2.30%	5.90%	2.20%	8.10%	0.00%	2.90%	7.30%	2.90%	6.81%	5.30%	2.30%	
3rd/4th degree tears (sustained at SVD)	2.80%	NA		1.00%	1.40%	3.90%	1.60%	2.60%	1.10%	4.90%	1.50%	1.10%	2.10%	0.50%	1.80%	
Episiotomy rate (instrumental)	86.70%	NA		85.40%	80.43%	81.50%	86.70%	87.20%	83.30%	79.40%	91.20%	94.70%	84.10%	89.70%	89.10%	
Episiotomy rate (SVD)	8.30%	NA		9.20%	6.08%	4.80%	6.90%	7.10%	8.90%	4.70%	5.90%	9.00%	5.00%	5.20%	3.90%	
No. of complaints opened in month	3	5	Datix	2	1	4	2	5	2	7	4	3	5	2	3	
Number of times the unit closed for admission	<1/month	>3/month	Risk Lead	0	0	2	1	0	0	0	1	1	0	0	0	
Smoking at booking	≤12.5%	≥12.6%	CMIS	6%	9%	5%	6%	7%	7%	7%	6%	5%	7%	5%	6%	
Smoking at delivery	≤6%	≥8%	CMIS	4%	6%	5%	6%	6%	6%	5%	6%	5%	5%	3%	3%	
Births>23+6 -36+6 weeks	<6% per month/year	≥7.5% in year	CMIS	8.68%	7.81%	5.90%	4.90%	7.50%	6.80%	7.70%	8.09%	7.60%	6.90%	7.30%	8.29%	Ongoing deep dive into any avoidable pre term births to be presented via governance reporting September 2023. 69% babies were over 34 weeks gestation and there were 3 sets of preterm twins .
Births>23+6 -26+6 weeks	TBC	TBC		0.20%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.30%	0.00%	0.00%	0.00%	
Steroid administration 2 doses < 7 days before birth	>55%	<40%	CMIS/records	83%	33%	50%	33%	88%	57%	67%	25%	29%	47%	50%	50%	Data and parameters changed to reflect updated MIS/SBLCB V3 parameters from Aug 2023 2/4managed appropriately for steroids < 7 days = 50%
Steroid administration 1 dose administered (% of cases occurring)Case reviews to take place to identify learning	No target	No target	CMIS/records	17%	0%	0%	33%	12%	29%	22%	50%	57%	14%	25%	25%	1/4 only one dose= 25%. No opportunity for second dose as birthed
Steroid administration 2 doses> 7 days before birth (% of cases occuring)	No target	No target	CMIS/records	0%	67%	50%	34%	0%	14%	11%	25%	14%	29%	25%	25%	1/4 woman received a full course of steroids > 7days before birth and this was appropriate to the clinical presentation
Magnesium Sulphate	80%	<80%	CMIS/records	100% (2/2)	100%(1/1)	0/0	100% (1/1)	0/0	100% (1/1)	0/0	100% (1/1)	100% (1/1)	0% (0/1)	0/0%	0/0%	
Fetal monitoring training compliance	≥90%	<80%		74%	82%	92%	93%	89%	89%	92%	93%	86%	93%	95%	94%	
Babies with low birthweight (<10th centile)	<9%	>10%	CMIS	1%	2%	0.80%	1.90%	2.00%	3.30%	1.70%	3.30%	0.90%	1.40%	2.20%	1.20%	
SGA detection rate <10th centile	>49.8%	<29.8	GAP		37.20%			34.50%			39.50%			37.80%		
Breast feeding initiated	≥72.7%	<72.7%	CMIS	72%	80%	77%	77%	78%	78%	79%	76%	79%	79%	79%	77%	
Breast feeding at discharge	≥72%	<72%	CMIS	66%	76%	76%	76%	77%	78%	78%	75%	77%	77%	75%	78%	

East and North Herts NHS Trust Perinatal Quality Surveillance Tool Highlight Report/Regional Perinatal Quality Oversight Group Highlight Report

Reporting Period: July 2023

KEY: CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

NHS England East of England

NHS

REGULATORY BODIES						
CQC DOMAINS						
Maternity unit rating: Inadequate (October 2022) Re inspected June 2023 and report awaited						
S - Safe E - Effective C - Caring R - Responsive W – Well led	S	E	C	R	W	Action Plan Status: To commence Progressing Completed
Rating (last inspection)						

External stakeholder concerns (please give brief reason)	
NMC concerns	None
GMC concerns	None
RCM concerns	None
HEE concerns	Yes slide 7
HSIB concerns	None
CQC concerns	Report provided slide 7
Total number of stakeholder concerns	2

CQC alerts (active alerts & year)	None
CQC warning notice (29a)	Yes – slide 7
Regulatory letters from coroner (28)	None
Maternity Safety Support Programme (Date of entry / stage)	January 2023

CNST MIS Safety Actions achieved (out of 10)				Ockenden investment (Total allocation)
Yr 1 (2019/20)	**Yr 2 (2020/21)**	**Yr 3 (2021/22)**	**Yr 4 (2022/23)**	
10	10	10	8	£482, 419

CQC Maternity survey results (2021)	
CQC Maternity survey overall rating - improvement since previous year (N)	Statistically significant increase -0 No statistical change – 35 Statistical decrease 11 **Overall rating - N**
Survey scores:	
Start of your care during pregnancy	4.3 worse than expected
Antenatal check ups	7.7 somewhat worse
During your pregnancy	7.8 worse
Your labour and birth	6.6 worse
Staff caring for you	7.4 worse
Care in hospital after birth	5.8 worse
Feeding your baby	7.6 worse
Care at home after birth	7.5 about the same
Other surveys	
GMC survey results (2022) overall satisfaction	76.47%

Clinical Outcome Measures

KPI (see final slide for detail)	Measurement / Target			Trust Rate (current reporting period)
				ENHT
Massive Obstetric Haemorrhage ≥ 1500 mls (as per NMPA descriptor, slide 8)	Vaginal birth		3.3%	1.31%
	Caesarean		4.5%	1.58%
3rd & 4th degree tear (as per NMPA descriptor, slide)	SVD (unassisted)		Unassisted 2.5%	1.8%
	Instrumental (assisted)		Assisted 6.3%	2.3%
Caesarean section (%age) (see guidance document)				
(primip, singleton , ceph, over 37/40, spontaneous labour)	Robson Group 1		N/A	26.1%
[primip, singleton, over 37/40, who had labour induced (2a) or LSCS prior to labour (2b)]	Robson Group 2	**2**	N/A	54.30%
		2a		47.06%
(Multip, at least 1 uterine scar, singleton, ceph, over 37/40)	Robson Group 5		N/A	87.80%
Smoking at time of delivery			≤ 6%	3%
Preterm birth rate	≤36+6 weeks (over 24+0/40)		≤6% annual rolling rate (Total PTB all babies 24-36+6))	Month: 8.29%
				Year: 7.29%

KPI (see final slide for detail)	Measurement / Target	Trust Rate (current reporting period)	
		x	
Term admissions to NNU Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet.	<6% (of total live term births)	5.6%	
	%age of total admissions that were avoidable	16%	1x avoidable Obstetric case – delay in anaesthesia. Case to be reviewed to determine grading of harm 2x avoidable Neonatal avoidable as babies could have been admitted to TC and remain with their mothers, rather than having been admitted into NNU.
Antenatal optimisation			
Right place of birth (≤27/40, 28 /40 with multiple or EFW<800g outside a maternity unit with a L3 NICU)	Number of births = 0	0	
Magnesium Sulphate Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior to birth.	80% (CNST)	0/0	
Antenatal steroids Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.	80% (CNST)	50% (2/2)	• 2/4managed appropriately for steroids < 7 days = 50% • 1/4 only one dose= 25%. No opportunity for second dose as birthed
Percentage of singleton live births (less than 34+0 weeks) occurring more than seven days after completion of their first course of antenatal corticosteroids	ND (indicator should be as low as possible)	25%	• 1/4 woman received a full course of steroids > 7days before birth and this was appropriate to the clinical presentation

MBRRACE stabilised & adjusted mortality rates per 1000 births		
Stillbirth	Neonatal Death term baby < 7/7	Extended perinatal
3.04	0.99	4.02

Transformation & Incident reporting

KPI	Measurement / Target		Trust Rate (current reporting period)
CONTINUITY OF CARER			
Percentage of women placed on CoC pathway (at 29 weeks)	% women placed on continuity of carer pathway at 29 weeks gestation		7%
Percentage of women on CoC pathway :Black, Asian / Mixed Black and Asian / areas of deprivation IMD1) (at 29 weeks)	Black, Asian, mixed Black and Asian	≥75% (for each element)	5%
	Most deprived 10% (IMD1) of neighbourhoods		NA

% of women (booking) – Black, Asian, mixed Black & Asian / 10% most deprived decile (IMD1)	Ethnicity data quality (%)	Post code data quality (%)	Request for Internal divert / Maternity deflect (if applicable)	Divert outside organisation
12%	100%	100%	0	0
0%				

Incident Reporting

Datix		Moderate harm and above incidents in month	Maternity Serious Incidents	Maternity Never Events
Unactioned (no / % forms received)	Open > 30 days (no/ % of all incidents)			
0	47	0	0	0
0%	8%			

LMNS confirmation of SI oversight

PMRT compliant (Ockendon IEA 1.4)	HSIB Cases (new)	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
		All	Term	Intrapartum		Early	Late	Direct	Indirect
Yes	0	0	0	0	0	0	0	0	0

StEIS Incidents reported 20/21 (by qtr)					StEIS Incidents reported 21/22 (by qtr)					StEIS Incidents reported 22/23 (by qtr)					StEIS Incidents reported 23/24 (by qtr)				
Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
0	3	0	1	4	1	7	5	4	17	1	1	3	2	7	1				1

Workforce / Births

Leadership and Specialist Roles

DoM in post	HoM in Post	Deputy HoM in post	Obstetric lead in post	Consultant Midwife in post	Retention Lead in Post	Lead PMA in post	MVP chair in post	Non exec director in post	Number of leadership & Specialist Roles not in place	Safety champions in place				Number of PMA's (no / WTE)
										Mat	Obs	Neo	Exec	
Yes	Yes	NA	Yes	Yes x2	Yes	Yes	Yes	Yes	2 – Patient Experience/ Safeguarding	Yes	Yes	Yes	Yes	No=10

Total births (mth / YTD)	Predicted annual births	Total bookings (mth / YTD)	LW co-ordinator supernumerary (%)	One to one care in labour (%)	BR+ completed in last 3 yrs (please give date)	Full assessment (Yes/ No)	BR+ recommended ratio	Actual ratio	Midwife no's	%age of total staff	Summary of gaps	Obs Consultant cover
381/4772	4980	463/5861	100%	100%	August 2021	Yes	1.24	1:23	24.78WTE	13%	All clinical areas experiencing shortages Ongoing recruitment/open day/staff in pipeline	125 hours/week

Assessed compliance with CNST MIS 10 Safety Actions		Y5
1	Perinatal Mortality review tool	Need to strengthen failsafe to ensure capture of lower gestation losses (particularly out of hours / weekends)
2	MSDS	
3	ATAIN	ATAIN action plan now approved by the divisional leadership and will be presented to QSC for approval in September.
4	Clinical workforce planning	
5	Midwifery Workforce planning	Birth-rate plus report awaited. Need to further improve data capture on acuity tool to ensure reporting of 1:1 care / S/N status of labour ward coordinator.
6	SBLCB V3	Need to ensure LMNS reporting pathway and strengthen implementation and evidence for elements 2 and 6
7	Service user feedback / Maternity Voice Partnership	
8	Core competency framework / Multi-prof training	
9	Board level assurance	
10	HSIB /Early notification scheme	
	Repayment of CNST (since introduction) Y/N and MIS yr	

Key (current position)
Compliant with all aspects of element
On track to achieve
Working towards (MIS & SBLCB) / Partially compliant (Ockendon)
Not compliant/ At risk

Evidence of SBLCB V3 Compliance

Element		
1	Reducing smoking	
2	Risk assessment , prevention & surveillance of pregnancies at risk of fetal growth restriction	
3	Reduced Fetal Movements	
4	Effective Fetal monitoring during labour	
5	Reducing pre-term birth	
6	Diabetes	

Assessment against Ockenden Immediate and Essential Actions (IEA) – to achieve full compliance will all elements of each IEA

IEA1 : Enhanced Safety	
IEA2: Listening to Women & Families	
IEA3: Staff training & Working Together	
iEA4: Managing complex pregnancy	
IEA5: Risk Assessment Throughout pregnancy	
IEA6: Monitoring Fetal wellbeing	
IEA7 Informed consent :	
• Fully compliant (self assessment)	

Training & Competency

Staff group	PROMPT	Fetal Monitoring	NBLS	ABLS	CCF
Obstetric Consultant					
Obstetric Doctors					
Obstetric Anaesthetic Consultants	83%				
Obstetric Anaesthetic Doctors	91%				
Midwives	94%	94%	95%	95%	95%
Maternity Support Workers	93%				
Neonatal and Obstetric Nurses	NA		96%	96%	
Overall	90.25%	94%	95.95%	95.5%	95%

Maternity unit	ENHT	
Themes arising from Perinatal Mortality Review Tool	• Risk assessments – the department do not use electronic patient records and are reliant on paper based solutions to strengthen the current Perinatal Institute records by adding stickers and documents as prompts. The risk of not having an electronic patient record system and the subsequent delay in the digital transformation project are recorded on the Divisional Risk Register with a rating of 10.	
Themes from review of all cases eligible for referral to HSIB	• No cases referred and accepted in July 2023	
Key actions being undertaken for incident logged as moderate or above	• Each case is prepared for MDT review with completion of RIR • Incidents are reviewed daily Mon-Fri by the Maternity Governance team to identify new moderate and above harm cases • Moderate harm and above cases are monitored using review tool, which also monitors duty of candour • All moderate and above harm cases are now presented via Governance reports • Regular meetings are held with CLU to discuss incidents/risks and mitigations • Twice weekly meetings set up on Teams to proactively gather the MDT in case any moderate harm or above cases are datixed.	
Feedback from MVP/Listening to women (sources, engagement / activities undertaken)	**Evidence of co-production** · Joined the LMNS team on several family centre visits, gathering service user feedback · Monthly CQC meeting in place with Trust to work on improvements following the visit with DoM · Attended Letchworth Baby event · Student midwife presentation taken place · Monthly mandatory training – MVP regular spot in place · MVP involved in Trust cultural organisation review interviews · Six-week social postnatal group visits taking place to gather feedback in the community · Postnatal project underway following successful focus groups and focusing on 3 workstreams of Communication, environment and access. · • Working with Lister Neonatal Families group to strength the links to neonatal work and projects taking place with families/service users	**Co-produced communications** · MVP survey developed to capture service user feedback · MVP working on an infographic to inform service users of the pathway of their maternity journey. **MVP feedback** · Tongue tie pathway review underway following service user feedback and experience **MVP update** MVP Co-Chair has stepped down and colleague has stepped up from Vice Chair to Co-Chair
Listening to staff (Staff feedback from frontline champions and walkabouts)	**July/ August 2023:** • Staffing • Delay in the digital transformation project affecting MEOW's on Nerve centre/ electronic patient records and centralised CTG monitoring. • Community care regarding cross border working, case loading and DNA pathways and processes. • Car parking for parents with babies receiving neonatal care	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	• January 2023– CQC	
Embedding learning (changes made as a result of incidents / complaints / activities / shared learning/ national reports)	Ongoing work with learning previously identified • Documentation for operative vaginal deliveries • All women discharged from inpatient setting to community care to have observations as part of handover of care to community team. • Training video completed to include in MDT training about fetal surveillance and professional conversations.	

	Exception reporting for compliance with national standards				
Trust/ Unit	**Initiative:** *Maternity Incentive scheme safety actions *Saving Babies Lives care bundle *Ockendon IEA	**Element/Safety Action/IEA**	**Reasons, mitigation in place, progress and actions to be undertaken, timescales due to be met to achieve compliance.**	Plan discussed with **Trust Board level Safety champion** and discussed at **LMNS board** meeting (Yes/ No)	
CQC	CQC Inspection report for maternity services. Inspection carried out 4th and 5th October with a reinspection 20th – 22nd June.		• Final Report received 20th January 2023. Rating confirmed as Inadequate. • Trust are part of the Maternity Safety support programme. • Materntiy Improvement plan in place and continues to be monitored and tracked through the weekly maternity improvement committee and monthly maternity senate.	Trust/ Date July 2023	LMNS/ Date
CQC Survey	CQC maternity services survey report	ENHT identified within the worst 8 performing Trusts overall for the 2022 survey and a decline from the previous years results	Particular focus for improvements identified as: • Being given appropriate information and advice on the risks associated with an induced labour. • Partners being able to stay as much as the mother wanted during their stay in the hospital. • Partners or someone else close to the mother being involved in their care as much as they wanted to be during labour and birth. • Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby. • Mothers being given information about their own physical recovery after the birth. • Added to the risk register as a reputational risk	February 2023	
HEE	Culture	Feedback related to experience of Midwives and Junior Drs. Action plan ongoing	• The Quadrumvirate are attending the perinatal culture and leadership programme focusing on strengthening quadrumvirate working and unit culture. A service wide culture and engagement staff survey	July 2023	

Midwifery workforce report July 2023

Purpose of Report:

When things go wrong in Obstetrics, it can be catastrophic and life-changing. Obstetrics represents the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend with claims representing 12% of all clinical claims but accounting for 62% of the total value of new claims; almost £6 billion.

The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. The Maternity incentive Scheme run by NHS Resolution (MIS) supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST and rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

Required standard:

The NHS Resolution Maternity Incentive Scheme stipulates that a bi-annual midwifery staffing oversight report is submitted to the Board and that the report includes evidence that:

- A systematic, evidence-based process to calculate midwifery staffing establishment is completed and that funded establishments reflect those calculated
- The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
- All women receive 1:1 care in labour
- A midwifery staffing report that covers staffing/safety issues must be submitted to the Board every 6 months, during the maternity incentive scheme year five reporting period.
- Where Trusts are not compliant with a funded establishment based on Birth-rate plus, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. This plan must also be shared with local commissioners.

Framework of Assessment:

In **November 2021,** a systematic midwifery workforce review was undertaken utilising the Birth-rate Plus (BR+) tool as endorsed by the RCM and the RCOG.

It is important to note that there is an updated review currently underway with a final report expected in September 2023. For the purposes of this paper, the staffing recommendations are taken from the **2021 paper**. It is expected that the only key significant impact within the 2023 paper will be based upon the provision for dedicated midwifery staffing for theatres.

ENHT – Clinical and Specialist Midwifery establishment

The activity results are based on the number of births between **1st April 2020 and 31st March 2021.**
The acuity data was based upon three months case mix data obtained for the period from **1st October 2020 to 31st December 2020.**

The total clinical establishment as produced from Birth-rate Plus® with 22.00% uplift of **214.07 wte** excludes the non-clinical midwifery roles needed to provide maternity services, as summarised below: -
Such as Director and Head of Midwifery, Matrons, Governance Lead, Bereavement Midwife, Antenatal / New-born Screening Midwives, Perinatal Mental Health, Practice Development, Infant Feeding, Diabetes midwives, Governance lead Fetal Medicine, PMA, Smoking Cessation Midwife, Pre-term Birth and multiple pregnancy Midwives.

In addition to the clinical staffing requirements **21.41 wte** is recommended for the above roles which equates to **10%.**
The current funded establishment for specialist roles is 15.3 wte , meaning a variance of 6.11 wte.

Baseline Staffing Requirements based upon Activity, Acuity and 5400 Births between 1st April 2020 and 31st March 2021.

East and North Hertfordshire NHS Trust

Breakdown of Birthrate Plus Recommended Clinical Staffing

• Total Deliveries 5400 • Total Community Cases 6080 (including HB) • Eligible for CoC 3725		
Delivery Suite: • Births • A/N cases • Non-viable pregnancies • In-utero Transfers escorted out	4170 420 30 38	61.46wte RMs
Triage	12610 episodes	10.13wte RMs
Birth Centre • Births • Transfers to DS • Ward Attenders • P/N care	945 324 440 899	17.54wte RMs
Dacre Ward • A/N Admissions • Induction of Labour Activity	1152 2462	10.93wte RMs
Gloucester Ward • Postnatal women • NIPE • Extra Care Babies • Postnatal readmissions	*4216* *included* *182* *178*	44.99wte RMs, RNs & B3s *(within skill mix for p/n care)*
Outpatients Services • Booking Clinics • Vaccination Clinics • Specialist Midwives Clinics • Fetal Medicine • Obstetric Clinics • Preassessment • Midwifery Scanning		7.37wte RMs
DAU service	11426 episodes	3.64wte
Community Services • Home Births • Community Cases • Attrition • Safeguarding	285 5795 1193	58.00wte RMs & B3s *(within skill mix for p/n care)*
Total Clinical WTE		**214.07wte**

The total clinical establishment will contain the contribution from Band 3 MSWs.

Most maternity units work with a minimum of 90/10% skill mix with Band 3 support workers on the Postnatal Ward/Community Service.

In addition, there is a need to have band 2 support staff. These roles are essential to the service but are not included in the Birth-rate Plus staffing review.

Summary of Staffing deficit – Updated August 2023

	Including 22% Recruitable Headroom			
Birth-rate plus recommended Clinical WTE Band 3-8	214.07			
BR+ recommended Clinical specialist and management roles (non clinical time). Recommendation based upon an average of 10% of the total clinical WTE	21.41	Current Budget Month 4 – 15.30 wte	Current Contract month 4 - 16.35 wte	Variance based on contracted to BR+
				- 5.06 WTE
Total Clinical, Specialist,& management WTE	235.48 WTE			

Current Budgeted Vs Worked Establishment:

	May 2023		June 2023		July 2023		Variance against BR+ Recommendation based on Month 4	
	Budget	Worked	Budget	Worked	Budget	Worked	Budget	Worked(inc Bank)
Band 5-8 Clinical, Specialist,& management	206.62	198.91	206.62	194.44	206.62	194.63		
Band 3-4	19.71	16.27	19.71	16.53	19.71	14.79		201.69
Total	226.33	215.18	226.33	210.97	226.12	209.42	-9.15	-26.06

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The total clinical establishment contains the contribution from Band 3 MSWs.

Most maternity units work with a minimum of 90/10% skill mix with Band 3 support workers on the Postnatal Ward/Community Service.

Band 2 roles while essential to the service are not included in the Birth-rate Plus staffing review.

Note:
Current budgeted establishment is inclusive of 21% Headroom of which 17% is recruitable in comparison BR+ recommends a recruitable headroom of at least 22%.

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Staffi

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Staff

Supernumerary Status of the Co-Ordinator:

NHS Resolution stipulates that the role of the midwifery coordinator is to provide oversight of the labour ward and support and assist other midwives which includes providing CTG " Fresh eyes", giving second opinions and reviews, providing assistance to midwives at birth and supporting junior midwives to undertake suturing etc. During exceptional circumstances, if the supernumerary status of the coordinator cannot be maintained, the expectation is that this is reported on Birth-rate Plus Acuity App as a red flag event, and also escalated via the Trust Enhance reporting system.

- 1 Episode of the coordinator not being able to maintain supernumerary status due to providing 1:1 care was reported on BR+ Acuity tool between 30/05/2023 and 31/07/2023 with a 76.9% confidence factor.

One to One care in Labour

1:1 care in labour is an outcome measure linked to safer staffing which is monitored on a monthly basis within both the Division and the LMNS.

A review of the maternity dashboard for the period 01/05/2023-31/07/2023 as identified that 100% of women received 1:1 care in labour. This same data is reflected within the Birth rate + Acuity reporting Tool.

	Updated/unchanged Goal	Updated/unchanged Red Flag	Data Source	May-23	Jun-23	Jul-23
1:1 care in labour excluding BBAs			CMiS	100%	100%	100%

Midwife to birth ratio

The actual v funded Midwife to birth ration is report on monthly in the materntiy dashboard.
The positive position in July reflects the low births in month rather than an increase in staffing.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Funded midwife only ratio Against YTD births	1:26	1:26	1:25	1:25	1:23	1:23	1:23	1:24	1:24	1:24	1:24	1:24
Actual midwife only ratio Against activity in month	1:27	1:31	1:26	1:25	1:24	1:21	1:22	1:26	1:24	1:26	1:26	1:23

Midwifery vacancy rate

The vacancy rate for July is 13% based on 21% headroom.
A strong pipeline of band 5 Midwives are due to commence in October

BR+ recommended ratio	Actual ratio	Midwife no's	%age of total staff	Summary of gaps
1:24	1:23	24.78WTE	13%	All clinical areas experiencing shortages Ongoing recruitment/open day/staff in pipeline

Next Steps:

- Await the report of the current Birth-rate plus establishment report.
- Prepare to present staffing model for theatres and recovery as part of next midwifery staffing report alongside birth-rate plus recommendations
- Progress and monitor the action plan to provide robust assurance in-line with the targets for supernumerary status of the co-ordinator and 1:1 care in labour.
- Continued focus on recruitment and also retention to ensure turnover and vacancy rates remain low and staff morale is improved.
- Onboarding of pipeline of newly qualified midwives joining the service in October 2023
- Continue to mitigate staffing rota gaps through proactive management, utilisation of temporary staffing and escalation pathways.

Using the Healthy Teams framework to support leadership and culture

East and North Hertfordshire NHS Trust

Over the last 9 months womens and neonatal services have been supported by the organisational development and people's team partners in applying a healthy teams approach to strengthen leadership and support cultural improvements and joint working across specialties and disciplines within services.

Freedom to Speak up

Team and 1:1 Coaching

Team Values Charters

Core management skills training

Bitesize leadership training

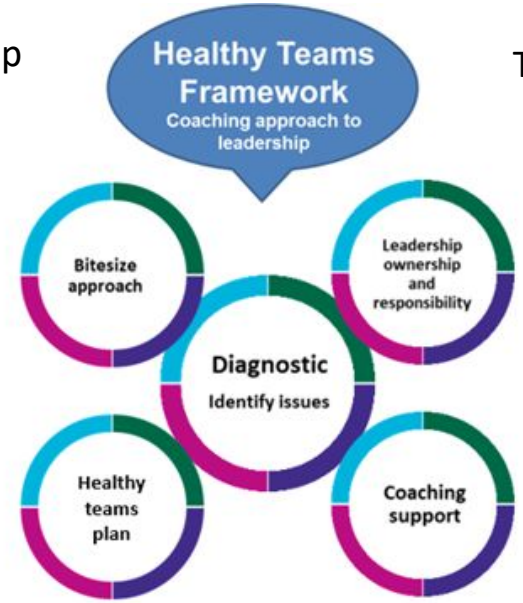
Grow Together conversations

Care support pyramid

Team away days

Culture and Kindness

Leadership development



Expected behaviours

Open forums

Heathy Teams work plan

Leadership Rhythm Leadership sessions

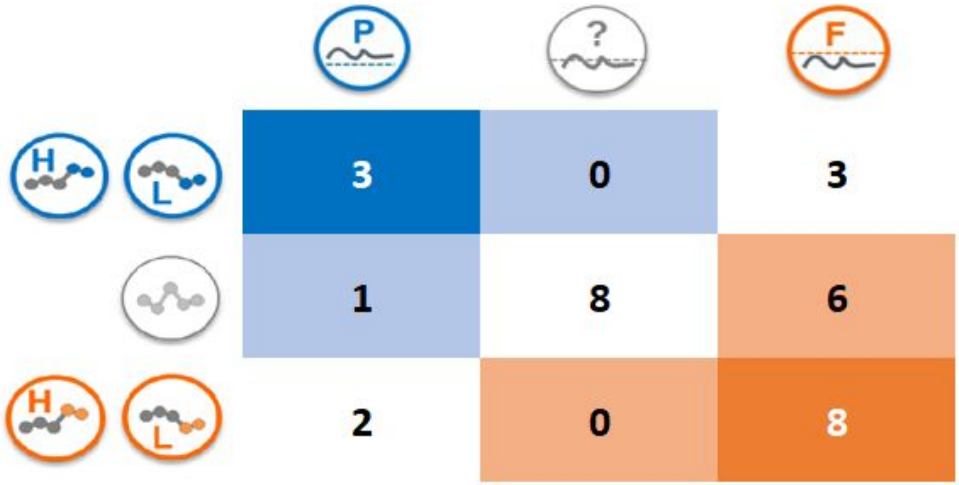
Hertfordshire and West Essex Integrated Care System

Presentation to: HWE Performance Committee
HWE ICS Performance Report

July 2023

Working together
for a healthier future

Executive Summary – KPI Risk Summary



Highest Risk	Programme
ED 4 Hour Standard	UEC
% in ED > 12 Hours	UEC
Ambulance Handovers	UEC
Adult 28 Day Standard	Mental Health
HPFT Early Memory Diagnosis (EMDASS)	Mental Health
RTT 78 Week Waits	Elective
RTT 52 Week Waits	Elective
Community Waits (Children)	Community

Lowest Risk	Programme
Learning Disability (LD) Health Checks	Primary Care
90% Stroke Unit	Stroke
CHC Assessments in Acute	Community

Low Risk	Programme
Adult Crisis 4 Hour	Mental Health

Variable Risk	Programme
GP Appointments	Primary Care
Dementia Diagnosis	Primary Care
2 Hour UCR	UEC
NHS 111 Calls	UEC
% Not Meeting CTR	UEC
2 Week Waits	Cancer
28 Day Faster Diagnosis	Cancer
Mental Health EIP	Mental Health
Out of Area Bed Days	Mental Health
RTT 104 Week Waits	Elective
RTT 65 Week Waits	Elective
Community Waits (Adults)	Community
CHC Assessments < 28 Days	Community

High Risk	Programme
Ambulance Response Times	UEC
4 Hour Stroke Unit	Stroke
Thrombolysed < 1 Hour	Stroke
62 Day Backlog	Cancer
62 Day Standard	Cancer
6 Week Waits	Diagnostics

Executive Summary

URGENT CARE, Slides 7-12: Calls abandoned performance = better than regional and national position; ED 4 hour performance = worse than regional and national position

- 111 percentage of calls abandoned remains relatively stable at c.10%, but adrift of the 3% standard. Recovery trajectory agreed for 23/24;
- Cat 2 mean ambulance response times remain relatively stable at 41 minutes for the ICS, but considerably adrift of the 18 minute standard. Recovery trajectories in development for 23/24;
- Ambulance hours lost to handover improved in April and May, but remain considerably adrift of target. Work underway to agree ICS recovery trajectories for 23/24;
- ED 4 hour performance remains at similar levels and is 4% adrift of the agreed recovery trajectory for May;
- Whilst data suggests that plans are starting to deliver small improvements in some areas, performance against improvement trajectories for UEC remains off track.

CANCER, Slides 26-27: 62 day first performance = better than regional and national positions, but 62 day backlogs increasing

- 28 day Faster Diagnosis performance failed to meet the 75% standard in April at 72.9%, but remains ahead of the national average;
- Patients waiting >62 days has increased for the last two months and is no longer meeting the agreed recovery trajectory. Referrals remain high and on-going industrial action continues to impact recovery;
- Performance against 62 day standard remains below target as providers continue to treat the longest waiting patients, however remains better than both regional and national position.

PLANNED CARE, Slides 22-23: 18 week performance = better than regional but worse than national position

- Recovery of patients waiting >78 weeks have been increasing since April and all HWE acute trusts will have breaches at the end of June. The remaining 78 week backlog is predominantly in Community Paediatrics (c.80%). The 65 weeks recovery trajectory was achieved in April, but the backlog has remained static through May & June. On-going industrial action continues to impact;
- ENHT have moved back into Tier 1 management for elective recovery;
- The total PTL and the number of patients waiting over 52 weeks continue to increase and remain of concern.

DIAGNOSTICS, Slide 24: 6 week performance = worse than regional and national position

- Diagnostic performance continues at a similar level, achieving 62.6% in April against the 99% national standard. Performance is below regional and national benchmarking, with PTL remaining static;
- System-wide diagnostic improvement plan in place, with 23/24 operational plan building on existing work to increase activity levels and decrease waiting times.

COMMUNITY, Slides 12-21

- The percentage of adults waiting less than 18 weeks improved to 91.5% in May;
- The volume of children on waiting lists continues to grow and 18 weeks performance has fallen to 49.4%, widening inequalities in access to community services between adult and children patient groups;
- Longest wait for children has increased to 97 weeks pressures predominantly in community paediatrics, as well as therapies and audiology services;
- Waits for Autism Spectrum Disorder (ASD) assessments and diagnosis are challenged in all three Places, with waits of up to 166 weeks. System wide plan is required to address the current backlog.

MENTAL HEALTH, Slides 31-37

- Demand remains high in Adult, Older Adult and CAMHS services with KPIs remaining below standard. Vacancies and recruitment remain the key challenges;
- Pressure for Mental Health Assessments and acute beds continues, however Out of Area Bed Days are continuing to reduce with improvement for the last five consecutive months;
- Dementia diagnosis in Primary Care remains challenged in Hertfordshire, but is an improving position. 61% was achieved in April against the 66.7% national standard.

PRIMARY CARE AND CONTINUING HEALTHCARE, Slides 38-39

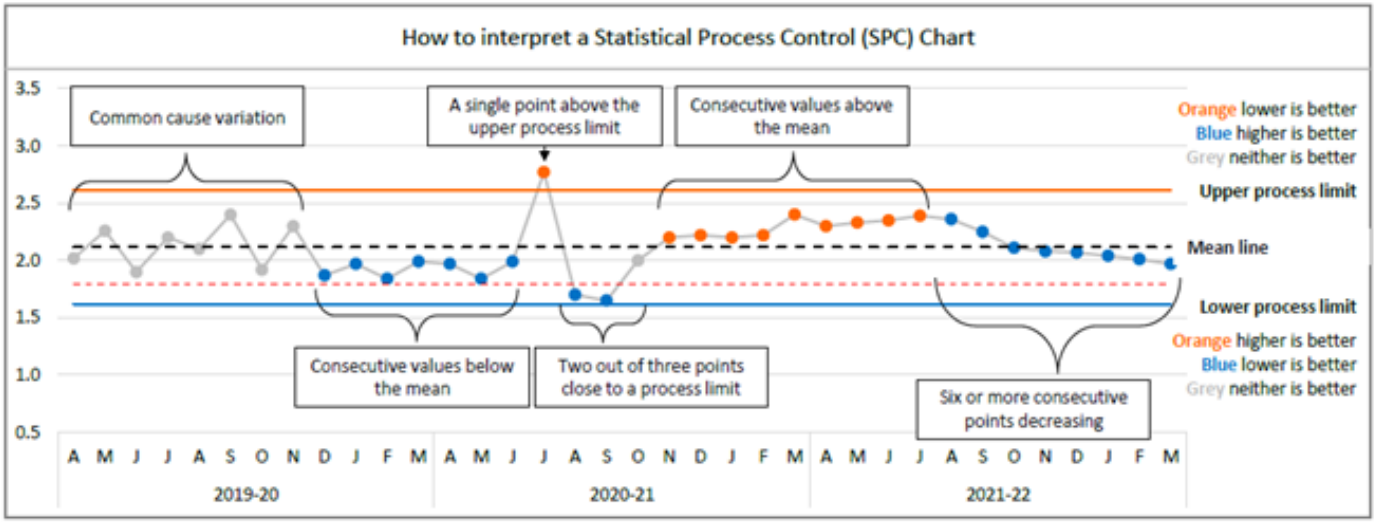
- Total number of GP appointments remain higher than pre-pandemic levels with the proportion of face to face appointments continuing above 70%. Further Primary Care reporting is being developed for inclusion in the next report;
- The percentage of CHC assessments completed within 28 days remains a challenge in South West Herts with an action plan in place. 62% was achieved in May against the 80% standard.

Executive Summary – Performance Overview

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
A&E - 4 Hour Standard	May 23	65.5%	76.0%			66.7%	61.4%	72.0%
A&E - % spending more than 12 Hours in Dept	May 23	9.7%	-			9.9%	7.2%	12.5%
A&E - ED Average Attendance	May 23	42089	-			40181	33412	46951
Trolley Waits	May 23	134	-			172	-66	410
2 Hour Community Response	Apr 23	76.1%	-			84.4%	70.1%	98.8%
14 day LOS	May 23	24.9%	-			25.0%	21.1%	28.9%
Ambulance - Handover >60 Mins	Mar 23	1581	-			991	680	1303
EEAST: Cat 1 - Mean (<7min)	Mar 23	00:09:30	00:07:00			00:09:38	00:07:47	00:11:29
EEAST: Cat 2 - Mean (<18 Mins)	Mar 23	00:56:22	00:15:00			00:54:36	00:14:16	01:34:57
RTT - 18 Weeks	Apr 23	52.3%	92.0%			57.0%	53.9%	60.2%
RTT - 52 Week Waits	Apr 23	9731	-			7438	5942	8933
RTT - PTL Size	Apr 23	146242	-			123788	116394	131182
RTT - 74 weeks	Apr 23	889	-			979	637	1322
Diagnostics - 6 Week Wait	Apr 23	62.6%	99.0%			64.6%	56.8%	72.4%
Diagnostics - PTL Size	Apr 23	24856	-			24807	19596	30017
Cancer - 2 Week Wait Standard	Apr 23	76.3%	93.0%			80.9%	68.1%	93.6%
Cancer - 2 Week Wait Referrals	Apr 23	4852	-			5076	3608	6545
Cancer - 62 Day Standard	Apr 23	66.5%	85.0%			72.8%	62.0%	83.7%
Cancer - 62 Day Total Waiting	May 23	564	-			590	368	812
Cancer - 104 Day Total Waiting	May 23	165	-			154	101	208
Cancer - 28 Day Faster Diagnosis Standard	Apr 23	72.9%	75.0%			70.2%	59.5%	80.8%
Mental Health - Out of Area Bed Days	Apr 23	995	-			939	606	1272
Mental Health - Dementia Diagnosis	Apr 23	62.9%	66.6%			61.7%	61.0%	62.4%
Mental Health - IAPT Entering Treatment	Apr 23	1978	-			2406	1409	3402
Early Intervention in Psychosis	Apr 23	60.0%	60.0%			82.5%	63.3%	101.7%

A Dashboard including Place and Trust based performance is included within Appendix A of this report

Statistical Process Control (SPC)

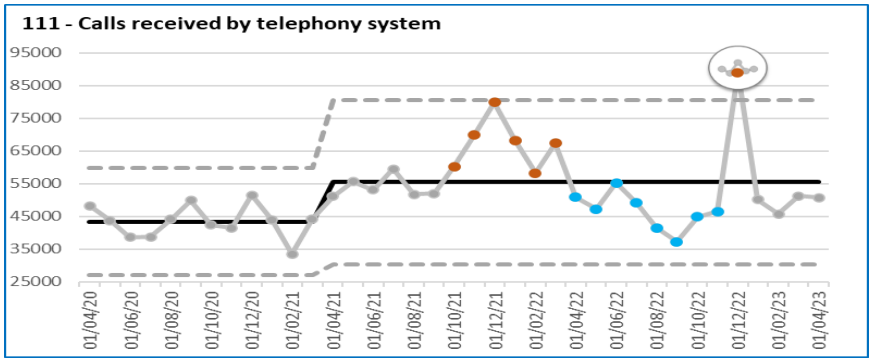


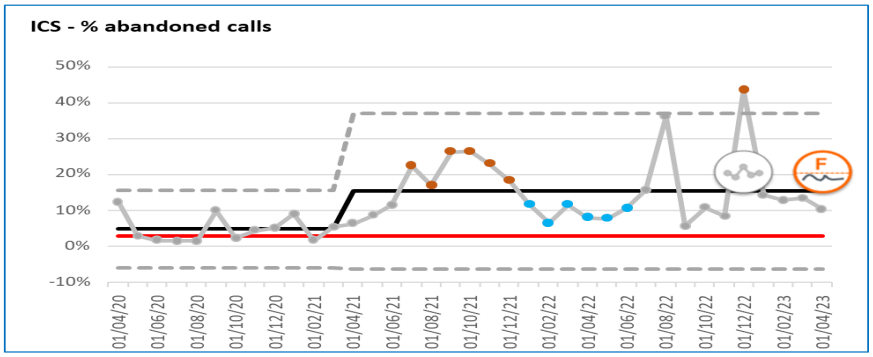
Variation	
H L	Special cause variation of concerning nature due to Higher or Lower values
H L	Special cause variation of improving nature due to Higher or Lower values
	Common cause variation No significant change

Assurance	
F	Consistent Failing of the target Upper / lower process limit is above / below target line
P	Consistent Passing of target Upper / lower process limit is above / below target line
?	Inconsistent passing and failing of the target

Performance by Work Programme

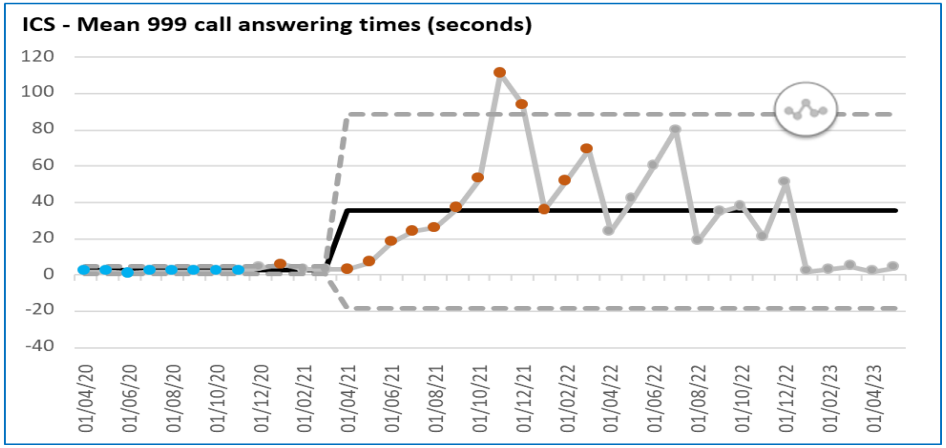
NHS 111

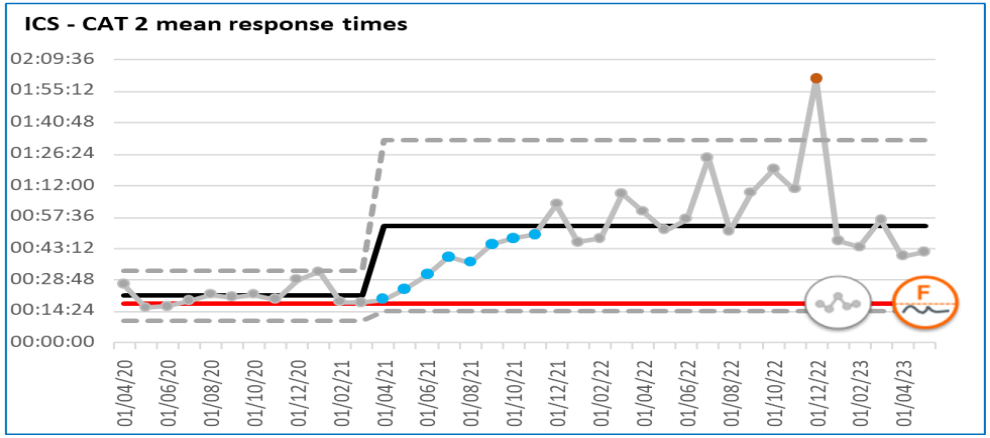


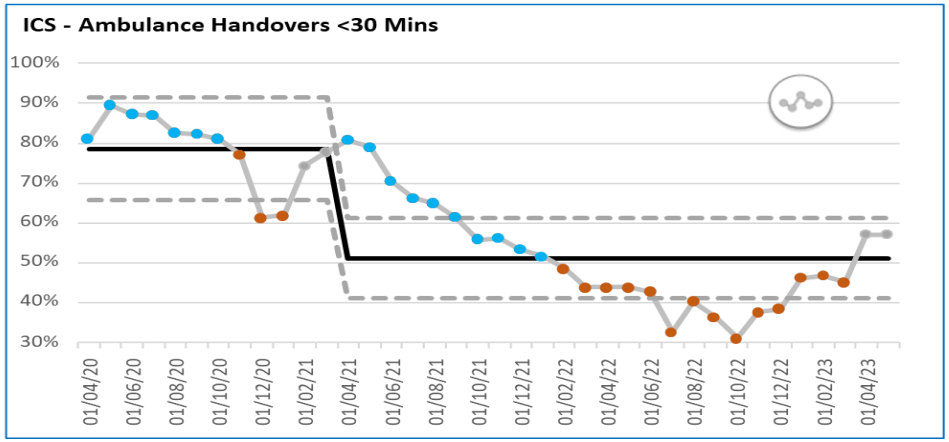


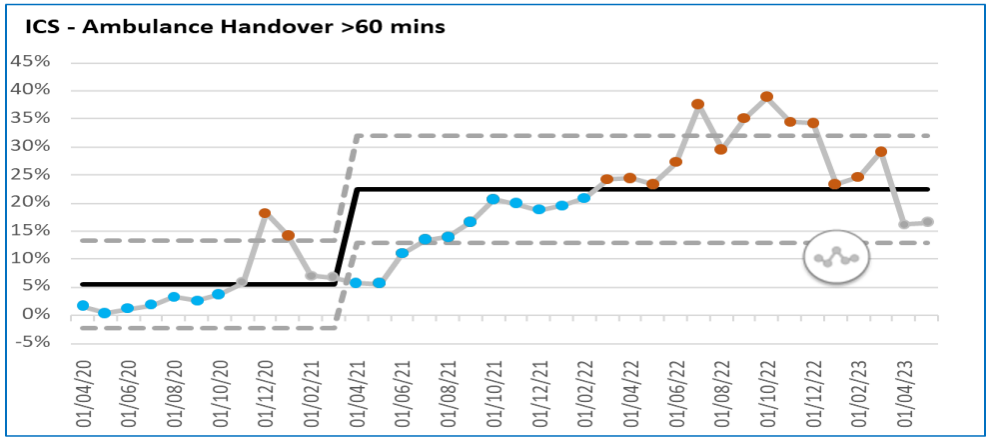
ICB Area	What the charts tell us	Issues	Actions	Expected Outcomes
HUC	• Call volumes have stabilised within common cause variation limits following the Strep A driven spike in December • Hertfordshire abandoned calls in April improved to 10.2% • West Essex abandoned calls improved to 10.9% • The level of variation between Hertfordshire and West Essex reduced from 1.7% to 0.7%	• High attrition rates and short notice sickness • Call volumes remain high at weekends • Increasing 111 online activity • Discussions ongoing to finalise 23/24 activity plans and finance	• Plans / trajectories in development to achieve the 3% abandoned call standard by March 24 • Clinical Navigator role implemented. Discussions underway with regard to repurposing the senior clinical workforce that this role now releases • Weekly IUC Overview Reports from the Provider with monthly updates on workforce • Pooling of CAS across HUC Footprint (HWE, BLMK, C&P) to support gaps in rota fill • Range of staff support and welfare measures in place • Review of 111 online activity • HUC Footprint group fortnightly meetings in place to oversee 23/24 contracts as well as identify and implement efficiencies improving the service	• Sharing CAS resource to strengthen clinical support where required across HUC Footprint (HWE, BLMK, C&P) • Efficiency findings planned to strengthen the services • Minimising gaps within the clinical rota fill

UEC - Ambulance Response and Handover

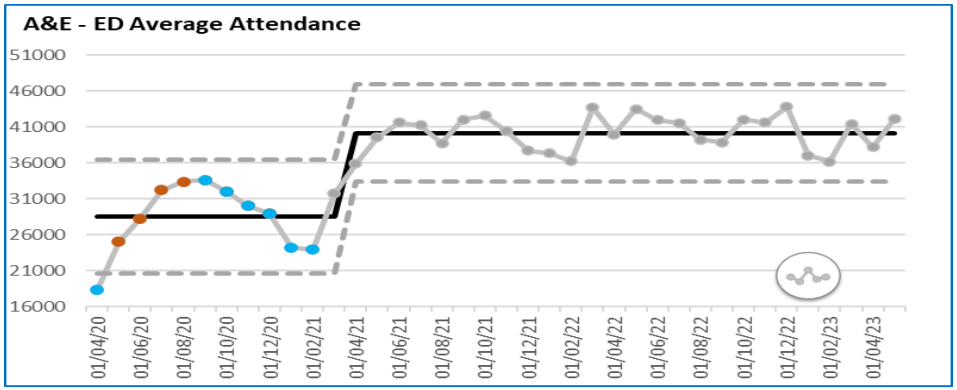


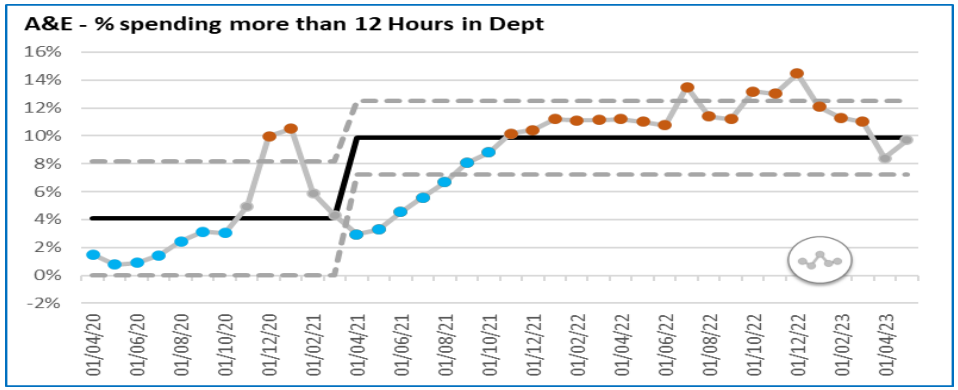


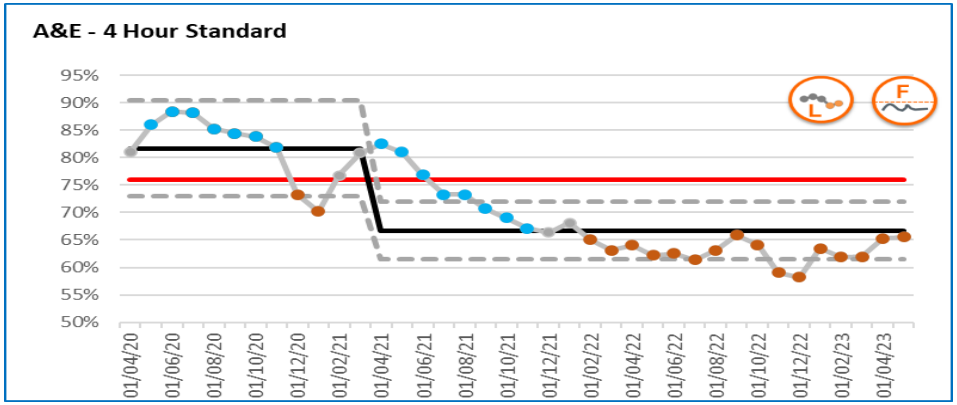


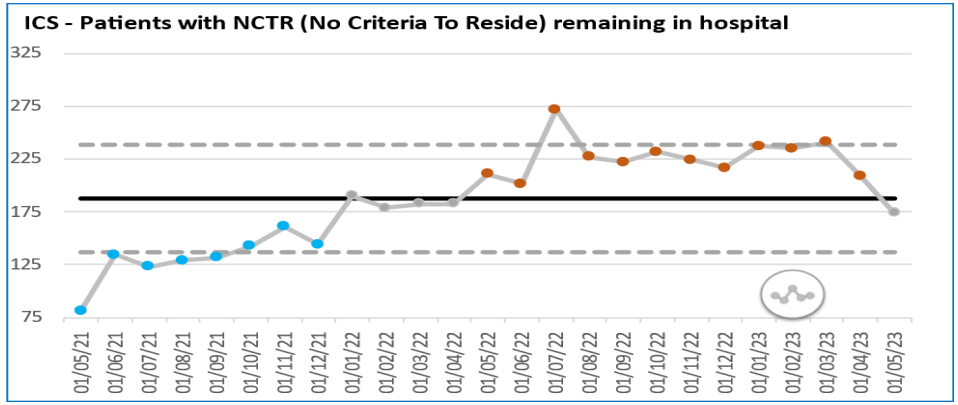


Urgent & Emergency Care (UEC)





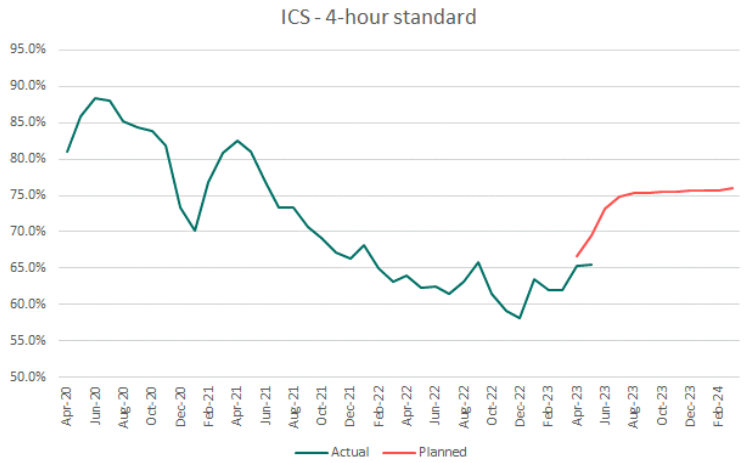




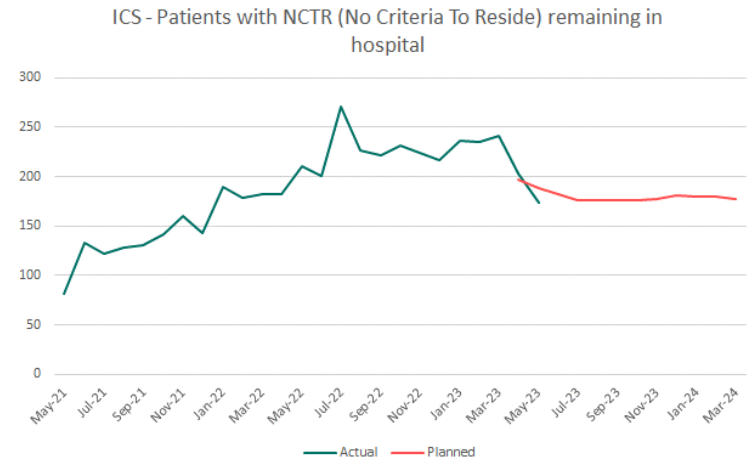
Place	Patient Journey	Area	Indicator	Target	Previous Month	Current Month	Latest Month	Month Change
WE CCG	At Hospital	Hospital flow	Patients with NCTR (No Criteria To Reside) remaining in hospital	-	49	13	May	↓
SWH CCG	At Hospital	Hospital flow	Patients with NCTR (No Criteria To Reside) remaining in hospital	-	71	85	May	↑
ENH CCG	At Hospital	Hospital flow	Patients with NCTR (No Criteria To Reside) remaining in hospital	-	89	76	May	↓

Urgent & Emergency Care (UEC) Improvement Trajectories

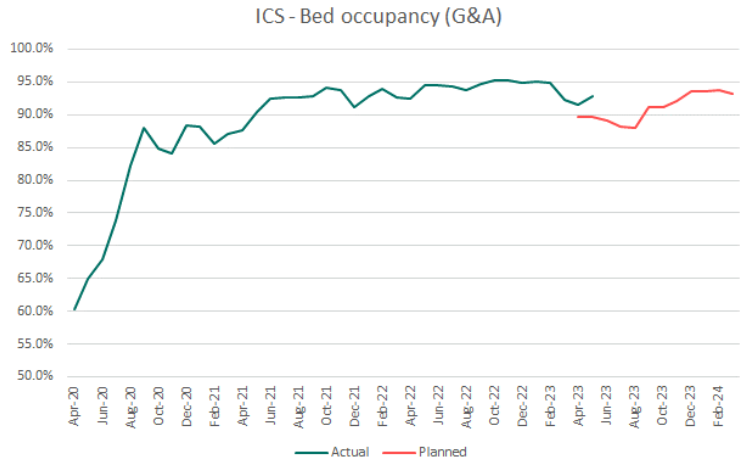
4 Hour Standard Improvement Trajectory



No Longer Meet Criteria to Reside (NLMCTR) Improvement Trajectory



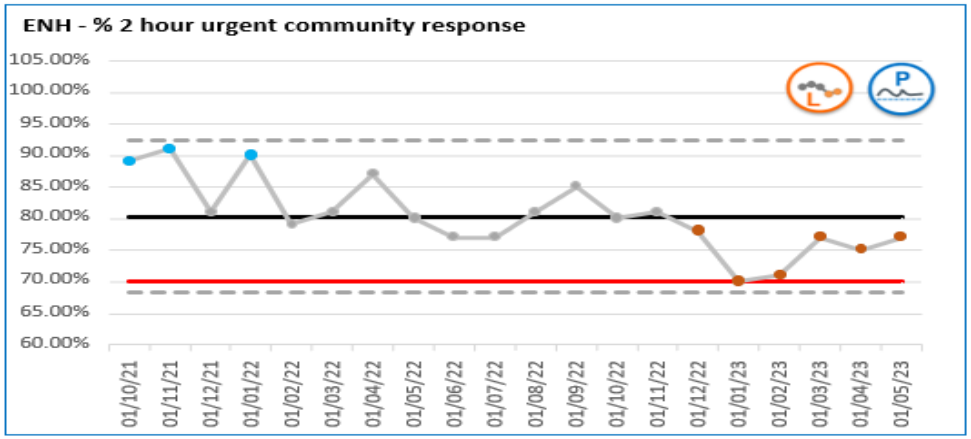
Bed Occupancy Trajectory

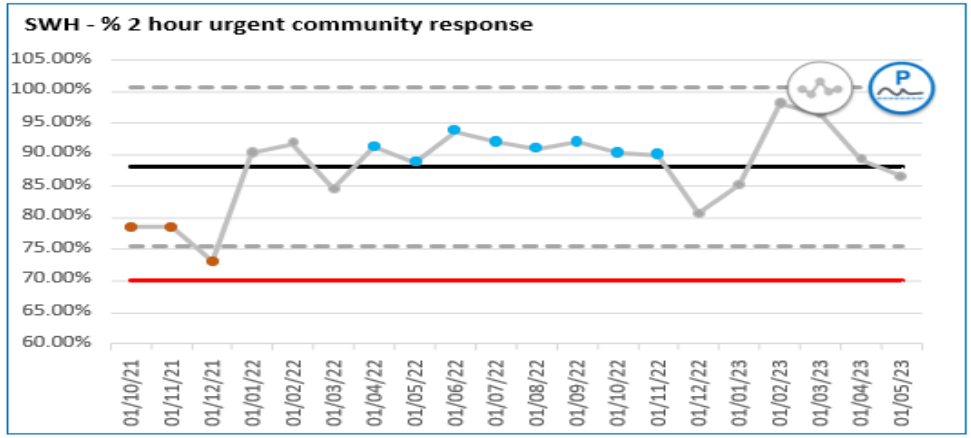


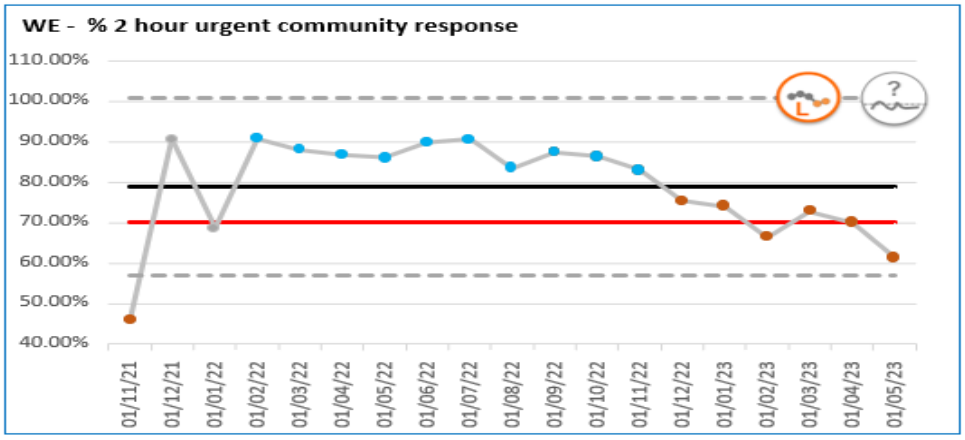
Urgent & Emergency Care (UEC)

ICB Area	What the charts tell us	Issues	Actions
ICB	• 999 call answering times have remained low with an average of 4 seconds in May. This is the 5th consecutive month with performance between 2 and 5 seconds • Average category 2 ambulance response times were 41 minutes in May. This is an improved performance compared to much of FY2223 but remains below the performance standard of 18 minutes and the recovery target of 30 minutes. Category 2 response times at a place level have not been available since Mar-23 • At an ICS level, ambulance handover performance has improved in April and May. In May the percentage of handovers over 60 minutes was 16.5%. However, this performance is largely driven by South West Herts (4%) rather than East and North Herts (25.9%) or West Essex (24%) • Performance against the 4 hour ED standard reached 65.5% in May. This is behind the recovery trajectory of 69.4%. • There is considerable variation at a Trust level for performance against the 4 hour standard in May: – WH = 74.1% – ENHT = 65% – PAH = 53% • The average number of patients per day remaining in hospital overnight who do not meet the criteria to reside improved from 209 in April to 174 in May. This is the lowest figure since Dec-21 and is ahead of the recovery trajectory of 189 for May	• Continued high demand and high acuity of patients for UEC services. However, ED attendances across the health system are lower in Jan-May 2023 than they were in Jan-May 2022 • Ongoing industrial action across various staffing groups has impacted recent performance • Staffing vacancies – e.g. c.80 vacancies at EEAST; 18 medical vacancies in PAH ED; 40% of staffing at St Albans Integrated Urgent Care Hub are agency • Staffing rotas in ED not always aligned to daily peaks in demand • Mental Health presentations remain high, coupled with a shortage of beds / assessment space • Low utilisation of virtual wards, in particular in West Essex • ED departments have a view that batches of ambulances are arriving at the same time and that intelligent conveyancing is not working as well as it should be • Hospital flow remains challenging with high occupancy rates, especially at PAH • Non-emergency patient transport delays	• EEAST testing for live full CAD in Robertson House has been conducted successfully • EEAST rapid release implemented in Mar-23 • ICS Intelligent Conveyancing fortnightly review meetings • East and North Herts – Handover@home / Access-to-stack - since June EEAST paramedics now have physical presence in Robertson House to pass patients over to EPUT / CLCH / HCT and reduce conveyances • East and North Herts – high intensity users project. 107 patients identified as high intensity users. Working with primary care to identify what additional support is needed for these patients • Lister – Extending medical SDEC opening hours and introducing surgical SDEC • Lister – co-located UTC expecting to mobilise from Nov-23 • 23/24 recovery trajectories in development for priority UEC Metrics. To be signed off at August UEC Board • West Essex external review of Virtual Ward. Workshop scheduled to agree resulting actions • St Albans Integrated Urgent Care Hub (IUCH) is now well established and utilisation has increased month-on-month. Plans in place to increase patient comms and redirect some patients from HHUTC • WHHT corridor nursing in place including a joint Trust and EEAST corridor SOP

UEC - Urgent 2 Hour Community Response





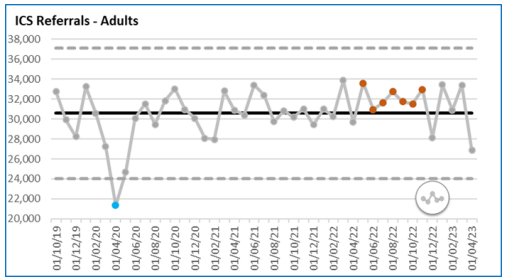


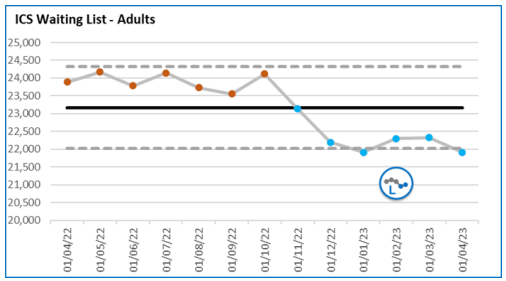
Activity	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
West Essex	468	465	428	337	451	519	395	403	442	466	376	348
East & North Herts	197	201	312	327	336	305	396	512	459	471	454	545
South & West Herts	157	162	165	124	163	139	165	154	103	136	203	222

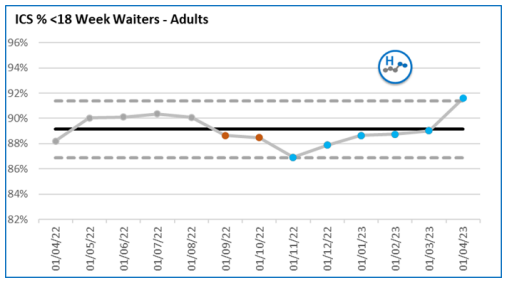
ICB Issues, escalation and next steps

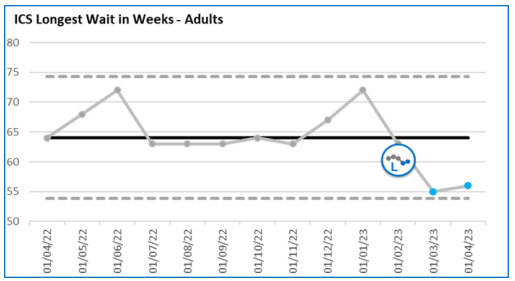
- The 70% standard was achieved in both Hertfordshire Places
- West Essex performance in May fell to 61.5%. Deterioration primarily driven by an administration issue in applying clock stops. Issue addressed and expected to quickly recover
- Additionally, issue of patients being referred in WE prior to A&E discharge being investigated
- The SWH EIV activity is now being captured and activity levels have increased as a result. SWH activity is still comparatively low however, indicating that the service is genuinely managing less patients than the other two places. Under investigation

Community Waiting Times (Adults)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Adults	33407	26868	↓	22322	21912	↓	89.02%	91.58%	↑	55	56	↑	April

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	7800	6844	↓	8833	8903	↑	90.41%	91.96%	↑	52	56	↑	April
ENH	AJM/Millbrook	107	105	↓	345	363	↑	82.03%	83.75%	↑	40	34	↓	April
ENH	**All**	**7907**	**6949**	↓	**9178**	**9266**	↑	**90.10%**	**91.64%**	↑	**52**	**56**	↑	**April**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	CLCH	7581	5702	↓	5149	4044	↓	76.87%	81.53%	↑	55	52	↓	April
SWH	Connect	3980	2981	↓	4003	4509	↑	94.50%	95.87%	↑	52	52	→	April
SWH	HCT	1059	838	↓	1140	1086	↓	94.65%	93.65%	↓	46	48	↑	April
SWH	AJM/Millbrook	121	109	↓	387	395	↑	83.20%	83.29%	↑	42	44	↑	April
SWH	**All**	**12741**	**9630**	↓	**10679**	**10034**	↓	**85.61%**	**89.36%**	↑	**55**	**52**	↓	**April**

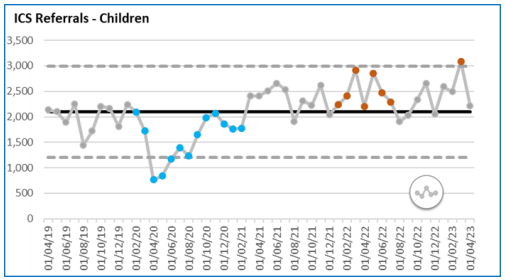
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT	12647	10190	↓	2334	2471	↑	99.96%	100.00%	↑	16	28	↑	April
WE	EPUT - Wheelchairs	112	99	↓	131	141	↑	97.71%	99.29%	↑	30	26	↓	April
WE	**All**	**12759**	**10289**	↓	**2465**	**2612**	↑	**99.84%**	**99.96%**	↑	**30**	**28**	↓	**April**

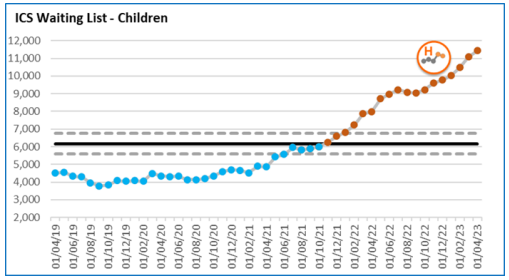
Community Waiting Times (Adults)

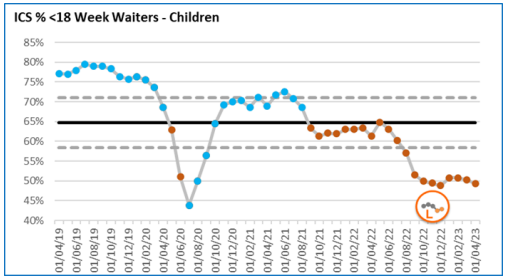
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Adult community services this include Skin Health (ENH), Respiratory (S&W), and Podiatric Surgery (WE). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained within Appendix D.

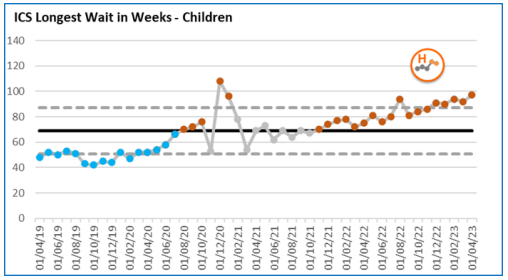
ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals are variable but within expected common cause variation • EPUT referrals appear high based on relative population size and this is being further investigated • The % of patients waiting less than 18 weeks continues to improve. Current performance is 91.6%, compared to the national average of 82.4% • The total number of adults waiting on waiting lists shows special cause variation of an improving nature • Particular improvement to waiting lists within CLCH. A combination of engaging with external provider to support long waits in Bladder & Bowel and Respiratory Services, and also changes to internal reporting and monitoring mechanisms to support reduction • Longest waits within HCT services in East & North Hertfordshire increased from 52 to 56 weeks • Consultant led 18 week RTT performance: ENH Skin Health – 90.5% SWH Respiratory – 72.7% WE Podiatric Surgery – 100%	**East & North Hertfordshire (ENH)** • Overall waiting within target performance is more favourable compared to the pre-pandemic baseline • Waiting times for the MSK Physio Service show clear improvement, and against the 12 week contracted target are better than 2019/20 **South & West Hertfordshire (SWH)** • Overall referrals have reduced, however they have increased in Heart Failure, Respiratory, Pulmonary Rehab, Planned Care, and Bladder and Bowel services • Although big reductions achieved since last reporting, Respiratory continues to hold the majority of long waiters. Consultant clinic capacity offered by WHTH does not meet current demand. However engagement has commenced with an external provider to support the service • Longest waiter currently within the Neuro service. This is a patient on PD nursing caseload • Staff sickness and vacancies are improving and processes are in place to monitor progress **West Essex (WE)** • Pulmonary Rehab - increased demand, return to face to face classes and long term sick impacting capacity • Bladder & Bowel impacted by lack of clinical space • Small numbers of wheelchair breaches due to supplier delays	**East & North Hertfordshire (ENH)** • Increasing MSK Physio capacity though estates and recruitment. Also continuing to review pathways. Initiatives are working well • All waits are closely monitored and are subject to robust internal governance **South & West Hertfordshire (SWH)** • Continue to review Respiratory long waits daily, prioritising those waiting the longest • Temporary Respiratory consultant capacity via bank and alternative Hospital Trusts • Respiratory consultant sessions with external provider implemented in February. This began with the provider reviewing the follow up caseload. In April, the provider began with clearing the 1st appointment backlog. Current wait for a 1st appointment is at 3-4 weeks which is well withing the 18 week target • External provider in place to support Neuro Rehab long waits. Initially 100 appropriate patients have been referred and seen. Further 175 patients identified. External provider seeing approximately 5 patients per week • Division specific recruitment plan developed which includes developing videos to compliment adverts and targeting social media channels • On going discussions with internal Divisions and system partners to look how resilience can be built for Neuro • Trajectories now in place for all services where there are waiting times concerns. These are reviewed and monitored weekly **West Essex (WE)** • Pulmonary Rehab deep dive completed and 23/24 funding discussions continue • Bladder & Bowel recovery plan in place to return to full compliance by 31st May. Patient list advisory letters sent to 8 patients over contracted standard • Wheelchair temporary equipment supplied where impact from supplier delays

Community Waiting Times (Children)









		Referrals			Patients Waiting			% waiting <18 weeks			Longest wait (weeks)			
Place	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ICS	Children	3085	2217	↓	11085	11434	↑	50.27%	49.40%	↓	92	97	↑	April

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	384	335	↓	1006	966	↓	77.53%	79.09%	↑	57	59	↑	April
ENH	AJM/Millbrook	16	23	↑	112	109	↓	80.36%	79.82%	↓	31	33	↑	April
ENH	ENHT Community Paeds.	383	230	↓	4022	4125	↑	25.68%	24.80%	↓	92	97	↑	April
ENH	**All**	**783**	**588**	↓	**5140**	**5200**	↑	**37.02%**	**36.04%**	↓	**92**	**97**	↑	**April**

Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	1620	1053	↓	5174	5379	↑	56.67%	54.73%	↓	71	75	↑	April
SWH	AJM/Millbrook	25	18	↓	98	97	↓	75.51%	82.47%	↑	30	34	↑	April
SWH	**All**	**1645**	**1071**	↓	**5272**	**5476**	↑	**57.02%**	**55.22%**	↓	**71**	**75**	↑	**April**

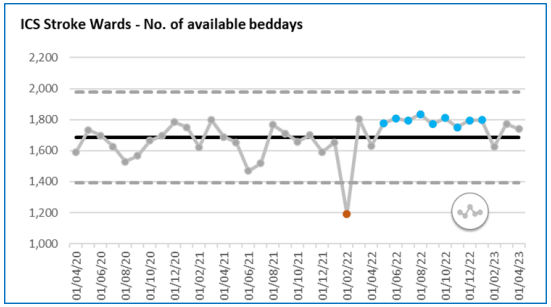
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	EPUT - Wheelchairs	22	13	↓	27	33	↑	96.30%	96.97%	↑	29	25	↓	April
WE	HCRG / Virgin	635	545	↓	646	725	↑	98.61%	99.03%	↑	46	26	↓	April
WE	**All**	**657**	**558**	↓	**673**	**758**	↑	**98.51%**	**98.94%**	↑	**46**	**26**	↓	**April**

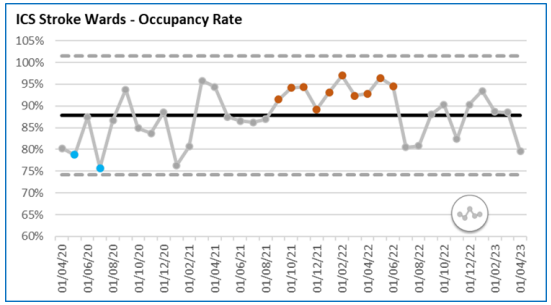
Community Waiting Times (Children)

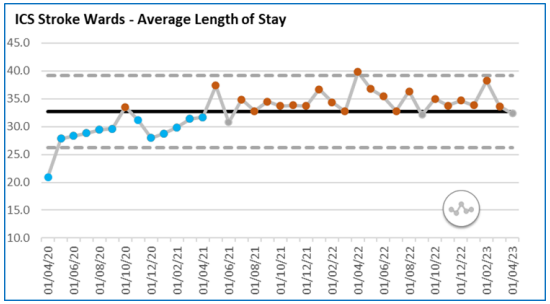
The NHS 18 week Referral to Treatment (RTT) standard only applies to consultant led services. For Children's community services this include Community Paediatrics (ICS wide) and Children's Audiology (SWH). Other services have locally agreed waiting times standards which may be 18 weeks or less. All services are shown compared to an 18 week target for an overall view of waiting time performance. Full detail of commissioned services in HWE is contained with Appendix D.

ICB Area	What the charts tell us	Issues	Actions
ICB	• Referrals are variable but within expected common cause variation • The total number of children on waiting lists continues to increase. There were 349 more children waiting in April than in March across the system • Each place saw lists grow, with the greatest increase within HCT services in South & West Hertfordshire • The % of children waiting less than 18 weeks remains of concern. Performance in April was 49.4%, compared to the national average of 62.7% • The longest waits are within the ENHT Community Paediatrics Service at 97 weeks. There are also long waits of up to 75 weeks within HCT services in South & West Hertfordshire • Consultant led 18 week RTT performance: SWH Community Paediatrics – 43.6% SWH Children's Audiology – 46.4% ENH Community Paediatrics – 24.8% WE Community Paediatrics – 100%	**Hertfordshire** • Waiting times in the SWH HCT Community Paediatrics service remains challenged. Service productivity shows clear improvement since 2019/20 (34%), but referrals have increased by approx. 30% • There is a rise in long wats for Paediatric Audiology in SWH. Investment initiatives in Audiology and Paediatrics are expected to deliver improvement during 2023/24 • Waiting times across Hertfordshire for Children's Therapies (OT, Speech & Language and Physiotherapy) are under pressure, including Education, Health & Care Plan (EHCP) elements **West Essex (WE)** • The volume of children on waiting lists continues to increase, predominantly in Community Paediatrics • However performance remains strong with only 7 patients exceeding 18 weeks across all services	**Hertfordshire** • Community Paediatrics in SWH is receiving non-recurrent additional investment, increasing workforce capacity and introducing new specialist nursing posts. Risk remains on recruitment to these roles. Transformation Programme Group established to take forward service redesign • Paediatric Audiology in SWH is focusing on higher priority appointments, especially follow up appointments. Signposting to interim advice whilst awaiting assessment. Analysis for workforce business case has resulted in Increasing capacity with recruitment of two posts, as capacity is not currently sufficient to meet demand. • Children's Therapies – increasing capacity through recruitment, waiting list initiatives and outsourcing • Working closely with commissioners on wider improvements across Special Education Needs (SEN) / Education, Health & Care Plan (EHCP) processes focusing on initial assessment backlogs **West Essex (WE)** • WE Community Paediatrics Business Case discussions are ongoing. The ask for additional investment into the overall continues to be negotiated

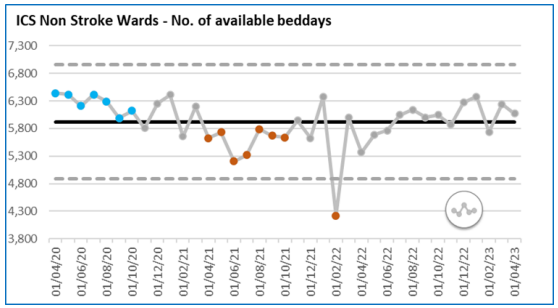
Community Beds (Stroke & Non-Stroke)

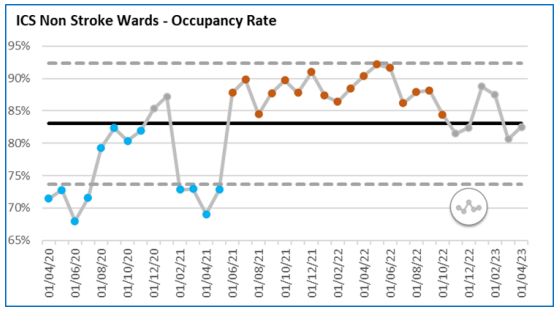


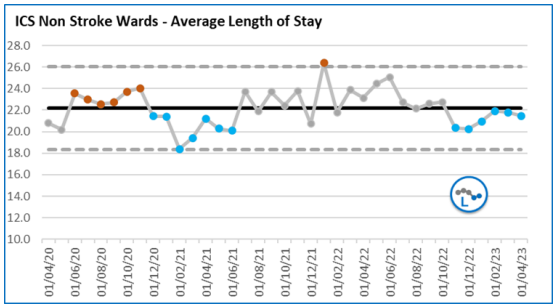




Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	720	720	⇨	92.92%	83.75%	↓	35.2	24.1	↓	April
SWH	CLCH	620	600	↓	78.55%	60.17%	↓	29.5	32.5	↑	April
WE	EPUT	434	420	↓	95.39%	100.00%	↑	36.0	44.3	↑	April
ICS	**All**	**1774**	**1740**	↓	**88.50%**	**79.54%**	↓	**33.7**	**32.4**	↓	**April**







Non-Stroke Wards		Number of available beddays			Occupancy Rate			Average length of stay (days)			
Place	Provider	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
ENH	HCT	1710	1670	↓	74.85%	81.32%	↑	25.6	23.2	↓	April
SWH	CLCH	2270	2214	↓	76.83%	71.50%	↓	27.2	26.3	↓	April
WE	EPUT	2263	2190	↓	88.78%	94.52%	↑	14.7	16.6	↑	April
ICS	**All**	**6243**	**6074**	↓	**80.62%**	**82.50%**	↑	**21.8**	**21.5**	↓	**April**

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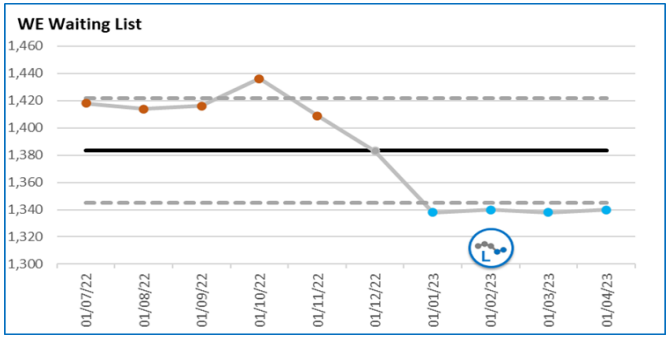
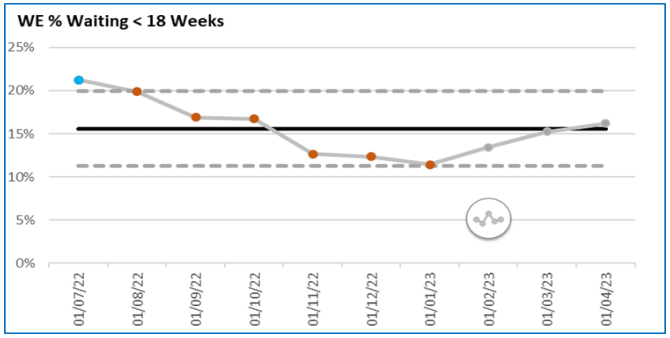
Community Beds (Stroke & Non-Stroke)

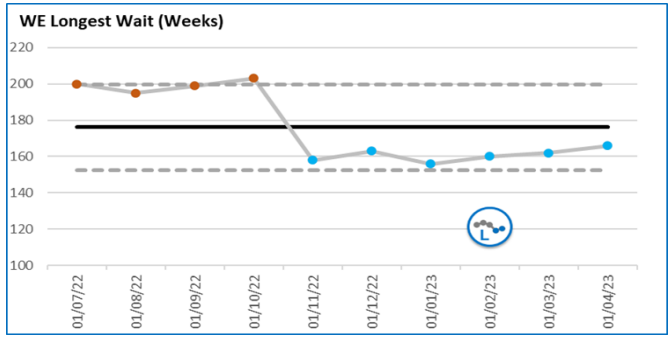
ICB Area	What the charts tell us	Issues	Actions
ICB	**Stroke Beds Days** • Available stroke bed days reduced slightly in April but remain within expected common cause variation limits • Overall occupancy rates across the system are within common cause variation limits but there is notable variation across the 3 Places. CLCH occupancy in April was 60%, with EPUT at 100% occupancy • Overall length of stay across the system is within common cause variation limits, but again there is notable variation across the 3 Places. HCT was 24 days in April, with EPUT at 44 days **Non-Stroke Beds Days** • Available bed days reduced in all 3 Places but remain within expected common cause variation limits • Overall occupancy rates across the system are within common cause variation limits but there is notable variation across the 3 Places. CLCH occupancy in April was 71%, with EPUT at 94% occupancy • Overall length of stay across the system shows special cause variation of an improving nature, but again there is notable variation across the 3 Places. EPUT was 16 days in April, with CLCH at 26 days	**East & North Hertfordshire (ENH)** • Danesbury Stroke and Neuro unit has improved its average length of stay and is operating within target • Occupancy is also on target at 92%. **South & West Hertfordshire (SWH)** • Small reduction in number of stroke and non-stroke bed days available due to on going building works • Increase in average length of stay due to complexity of patients **West Essex (WE)** • High levels of referrals and admissions resulting in high occupancy rates • Two long stay stroke patients > 6 weeks • High volume of Discharge to Assess (D2A) patients awaiting Care Homes; 1 long stay patient > 3 months • Further investigation to understand the comparatively high stroke beds length of stay	**South & West Hertfordshire (SWH)** • Delay assurance calls remain in place with HCC with clear escalation process in place • Currently reviewing all process to manage patients in and out of wards **West Essex (WE)** • All patients awaiting Care Homes reviewed on daily social care escalation call

Autism Spectrum Disorder (ASD) – West Essex

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
WE	HCRG	Children	1338	1340	↑	15.25%	16.19%	↑	162	166	↑	April



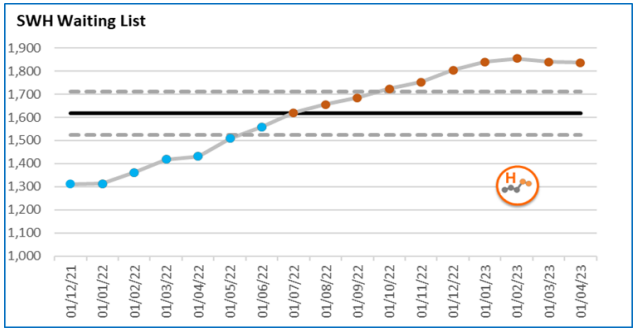


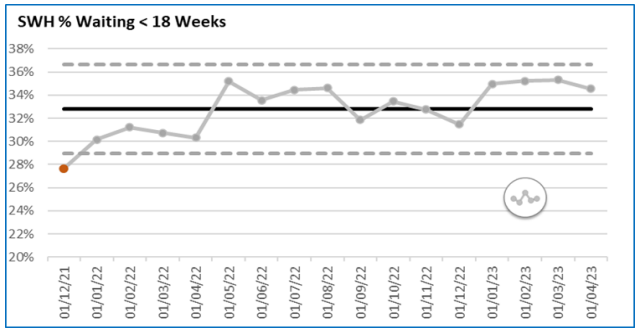


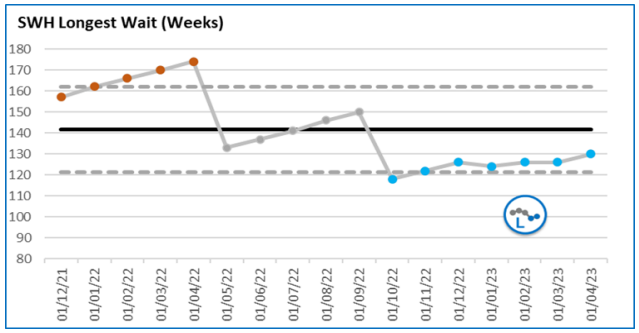
ICB Area	What the charts tell us	Issues	Actions
West Essex	• The ASD waiting list showed good improvement following agreement of a recovery plan in late 2022 • There has been no further reduction to the waiting list since January and the recovery plan is behind trajectory • The % of ASD waiters < 18 weeks has improved for the last three months, but remains comparatively low at c.16% • Longest waits in the service have improved from a high of 200 weeks, but are largely unchanged since November 22 and also behind trajectory	• Referral rate remains above commissioned capacity, even with the additional backlog funding, and therefore waiting lists and times are not reducing • Some underperformance as a result of low capacity in both HCRG and Mind Professionals, although being closely monitored and getting back on track • Backlog funding expected to be exhausted by Aug 23, after which waiting lists are expected to return to a position of growth • Further 31% projected demand increase by 2026 • Outstanding decision with regard to business case to increase core capacity	• Business case submitted to WE HCP during 22/23 Q4 includes additional ASD capacity • Community Paediatric capacity fully staffed and recruited to at-risk, with additional Associate Specialist doctors focusing on ASD • Specialist SLT role has been filled • WE Neuro Steering Group initiated work plan focused on 'waiting well', aligned to local and Essex wide deliverables

Autism Spectrum Disorder (ASD) – South & West Hertfordshire

			Patients Waiting			% waiting < 18 weeks			Longest wait (weeks)			
Place	Provider	Age	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Previous Month	Current Month	Month Change	Latest data
SWH	HCT	Children	1840	1836	↓	35.33%	34.53%	↓	126	130	↑	April

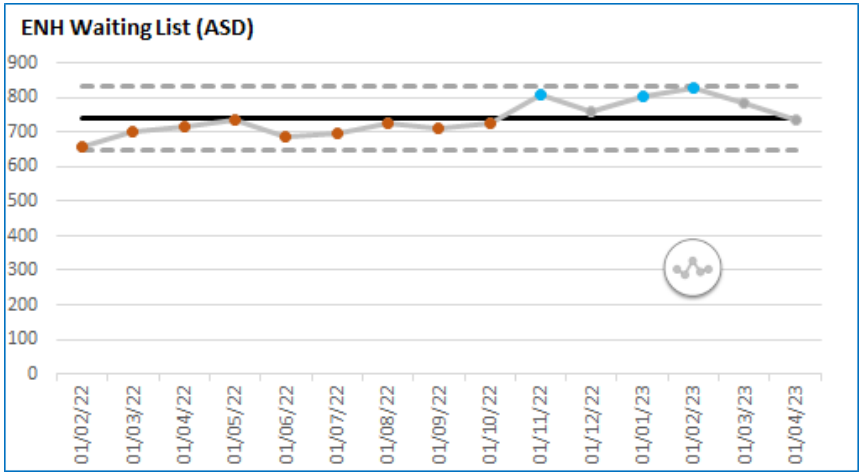






ICB Area	What the charts tell us	Issues	Actions
South & West Herts	• Steady increase in the overall ASD waiting list since January 22 • Waiting lists saw small reductions in March and April 23, but remain significantly above the historic mean • The % of ASD waiters < 18 weeks fluctuates around a historic mean of c.33% • The longest waits within the service have been steady at 120 – 130 weeks for the last 8 months • Impact of the increased internal and outsourced capacity for autism assessments seen in the latest local data	• Neurodiversity Support Centre (Single Point of Access for parents, carers and professionals) is a pilot with funding ending in March 2024. Longer term investment decision required • Backlog funding will end March 2024. Without additional investment, waiting lists will return to a position of growth • Capacity in existing services does not meet demand • Further increases in demand predicted	• Significant additional diagnostic assessments have been delivered through joint outsourcing to Avenue Therapies Ltd and The Owl Centre Ltd • Additional internal capacity and improved processes • In 2023/24 HCT will continue with outsourcing using the remaining funding from the initial business case at £437k • Learning Disabilities, Mental Health and Autism Collaborative are continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with autism and / or ADHD. Currently pilot funding and decisions with regards to long term funding will need to be made • The Owl Centre outsourcing continues at pace. Activity levels are being maintained across the summer holiday, prioritising CYP due to transition to secondary school on the waiting list and with increased face to face assessments for CYP aged 5 and 6 • EPs allocated to clinics with SLTs for quality check assessments • Clinicians have agreed future best practice clinical pathway and model for Hertfordshire and this is due to be reviewed by operational teams to plan staff model and capacity required

Autism Spectrum Disorder (ASD) – East & North Hertfordshire



- In East and North Hertfordshire patients have a first appointment with Community Paediatrics. If the clinician then considers that the patient requires an ASD assessment then they are added to the ASD waiting list.
- Data is available on the waiting times for the first community paediatrics appointments and also for ASD assessments once a patient has been added to the ASD assessment waiting list. However, data is not available for both pathways combined
- The chart opposite shows the trend in the number of patients waiting for an ASD assessment once they have been referred by a community paediatrician
- The table below summarises how long patients on the ASD waiting list have been waiting (as of Jun-23):

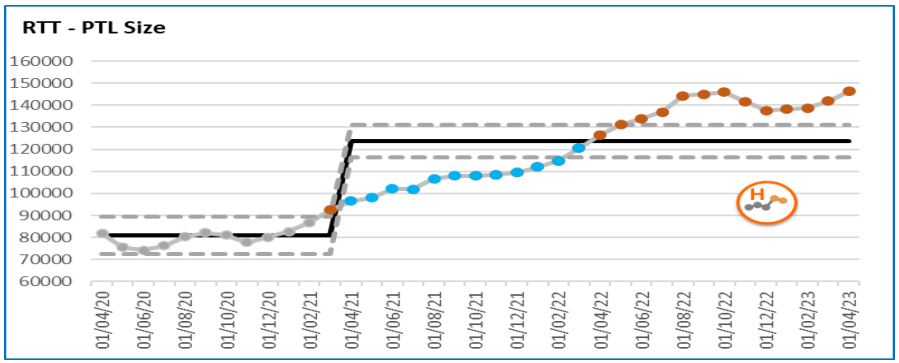
Summary of ENHT ASD assessment waiting list

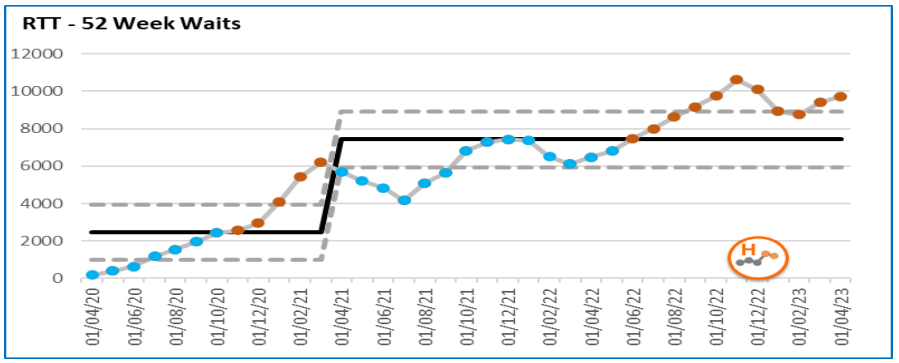
Waiting list bucket	Number of patients	% of patients
<18 weeks	139	17%
18 – 65 weeks	444	56%
66 – 78 weeks	64	8%
>78 weeks	152	19%

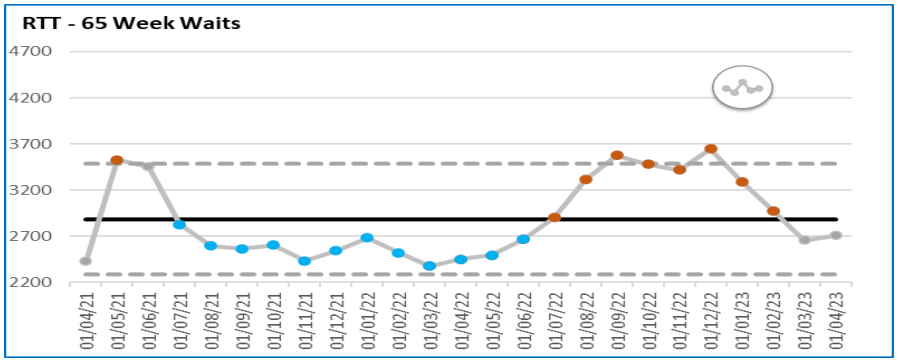
ICB Area	What the charts tell us	Issues	Actions

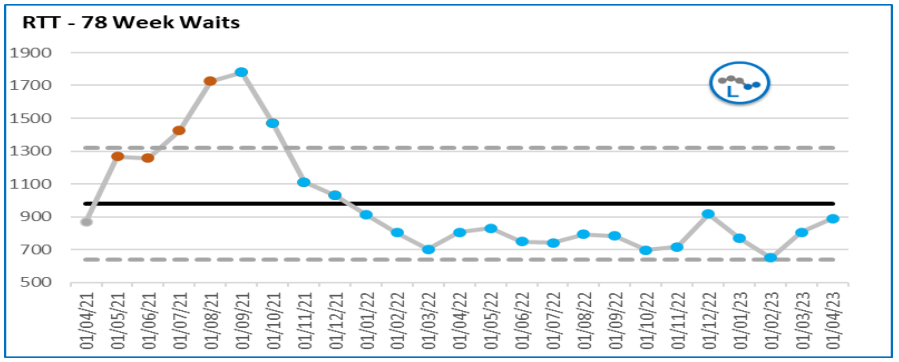
East & North Herts	• The ASD waiting list has been increasing steadily at an average rate of 8 patients per month over the last 12 months. However, in Mar-23 and Apr-23, the ASD waiting list reduced in size
	• The waiting list shown above does not include patients who are waiting for their first community paediatrics appointment, even if they have been referred by their GP as query ASD. It only shows patients who have been assessed by a community paediatrician and referred for a detailed ASD assessment
		• Data not currently reportable on the same basis as the other two ICB Places
		• ENHT is currently subject to fortnightly Tier 1 Oversight and Scrutiny meetings for Community Paediatrics with NHSE/I as a result of increasing >78 week waiters
		• Backlog funding will end December 2023. Without additional investment, waiting lists will return to a position of growth
		• Further increases in demand predicted
		• Neurodiversity Support Centre (Single Point of Access for parents, carers and professionals) is a pilot with funding ending in March 2024. Longer term investment decision required
			• ENHT and HWE ICS are currently putting in place a recovery plan for the community paediatrics service in ENH. Actions from this plan relating to ASD include:
			  • Exploring whether there is an opportunity to outsource additional ASD diagnostic assessments
			  • For those with suspected ASD over age of 7yrs, exploring new pathway direct from primary care to OWL to undertake the assessment from initial appointment to discharge
			• Between Dec-22 and Apr-23, 177 patients have been diagnosed with ASD through the OWL centre pathway
			• Learning Disabilities, Mental Health and Autism Collaborative continuing to develop support offer for parents, carers, families and CYP with behaviours and / or needs associated with autism and / or ADHD. Currently pilot funding and decisions with regards to long term funding need to be made
			• Clinicians have agreed future best practice clinical pathway and model for Hertfordshire. To be reviewed by operational teams to plan staff model and capacity

Planned Care – PTL Size and Long Waits





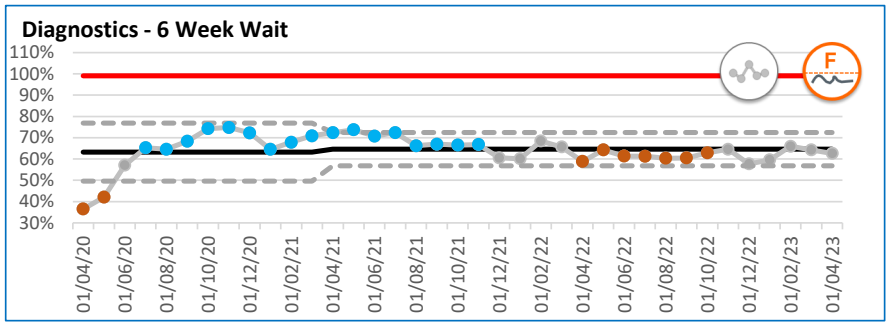


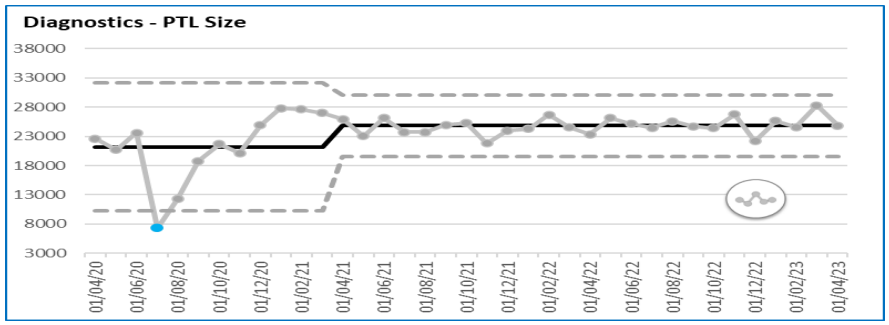


Planned Care – PTL Size and Long Waits

ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWE	• The overall PTL size has been steadily increasing over the last four months, mainly at both ENHT and WHTH, whilst PAH has remained steady. • March & April have seen an increased number of patients >78 weeks with ENHT increasing the most. • The number of patients waiting >65 weeks saw a significant drop between Dec '22 – March '23 however, April has seen an increase. • The number of patients waiting over 52 weeks has seen an increase over the last three months and therefore remains an area of high concern.	• Not enough activity is being delivered to manage the backlog effectively • Staffing remains a challenge, particularly Anaesthetics & Community Paediatrics at ENHT • ENHT growth in 78 week waits is primarily in Community Paediatrics • Trauma and Orthopaedics and Community Paediatrics remain the main areas of pressure • The impact of on-going industrial action is seen in the increasing waiting lists although Trusts are managing the IA well	**Management of waiting lists:** • System focus on reducing number of patients waiting >78 weeks and >65 weeks, with regional and national oversight • ENHT has returned to Tier 1 for elective recovery • The industrial action impacted the 78ww trajectory; PAH & WHTH are now projected to clear 78ww in July '23 and ENHT in September '23 (excluding Community Paediatrics) • Demand, capacity & recovery plans are in place to monitor 78 & 65 weeks • Weekly KLOEs in place with NHSE to track 78/65 week position • Fortnightly performance meetings with each of the three acute Trusts are in place with NHSE support • Validation and robust PTL management in place **Increasing Capacity and Improving productivity:** • Pro-active identification of pressured specialties with mutual aid sought vial local, regional & national processes • Maximising use of ISP capacity and WLIs where possible • Three accelerated pilot schemes identified to reduce community paediatrics waits in ENHT: 1) ENHT ADHD diagnosis and ongoing management combined with HPFT to form a single Hertfordshire service, 2) Implement primary care-led ADHD follow-up service for ENH patients and 3) explore if the Owl Centre (non consultant led ASD diagnostic service) can provide 200 additional ASD diagnostic assessments under the current procurement up until March 2024 • Theatre Utilisation Programmes in place including an ICB wide programme • Anaesthetist recruitment	• Actions delivering overall reductions to long waiting patients • National emphasis on prioritising patients in order of clinical need resulting in longer waits for routine patients • Clinical harm reviews and regular patient contact to manage patient safety and experience • System wide Community Paediatrics plan in development

Planned Care – Diagnostics





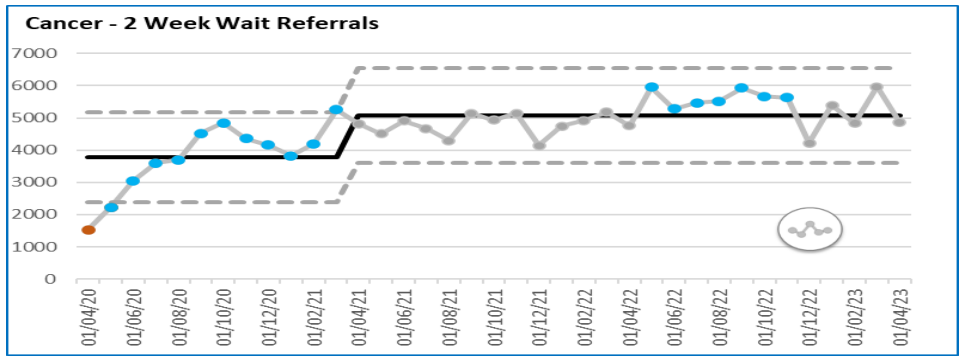
ICB Area	What the charts tell us	Issues	Actions	Mitigation
HWEICB	• 6 week wait performance across the system deteriorated by 3.4% between February and April • ENHT 6 week wait performance fell by 7.1% • Demand continues to increase, but the overall PTL remains within common cause variation limits	• Workforce remains the biggest area of concern • DEXA continues to be a key risk area at ENHT and WHTH; this is mainly a staffing issue • MRI & CT performance at ENHT remains challenged • Audiology and Endoscopy (esp. Cystoscopy) are the key challenges at PAH	• DEXA has been escalated to the Imaging Network (IN) and NHSE for additional support • Meeting with IN and NHSE taking place on 22 June. WHTH are looking to outsource to a 2nd provider, but they are awaiting CQC registration • WHTH have recruited additional Echocardiography staff and are now nearly fully staffed. Additional sessions are being scheduled and improvement is being seen in the latest May data • PAH Audiology: 12 of 20 patients offered to be seen at ENHT took up the offer. PAH are now looking to expand the offer from the initial focus of Herts border patients, however the process is resource intensive. Potential outsourcing with Spec Savers subject to agreement of funding • WHTH are trialling telephone assessments for Audiology (where appropriate) based on learning from N&W. Will also be outsourcing from July. Additional room space is required • Mutual Aid policy agreed at Planned Care Committee in June • Revised WHTH Endoscopy bid with NHSE for approval. Updated based on feedback that there was not enough capital funding to cover total costs • New QEII CDC is transitioning to business as usual. Echos and ECG are live; Holter is due to start w/c 19 June; Respiratory is expected to mobilise soon. Most imaging modalities are over performing, but need to be aware that no guarantee of funding for over performance.	• Continued use of insourcing / outsourcing where funding permits • Use of mutual aid • Use of telephone assessments being trialled • Validation of lists • Workforce issues to be escalated to ICS Workforce Supply Committee

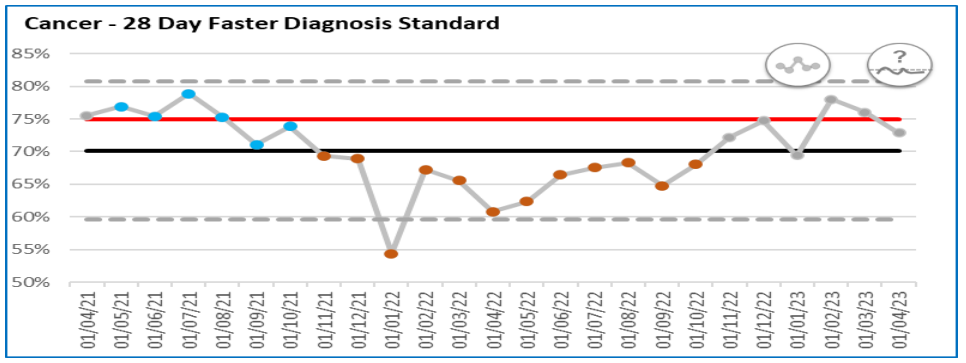
Planned Care – Theatre Utilisation

May 2023 (compared with March 2023)				
Metric	HWE System	ENHT	PAH	WHTH
Number of Theatres	39	17	10	12
Number of cases	720	324	162	234
Utilisation – Capped	76% ↓	80% ↓	77% ↓	70% ← →
Average Late Starts (mins)	33 ↑	28 ↓	40 ↑	34 ↑
Average Intercase downtime (mins)	13 ↓	14 ↓	12 ↓	11 ↑
Average early finish (mins)	78 ↓	61 ↓	73 ↓	96 ↓
Average unplanned extensions (mins)	56 ↑	56 ↑	35 ↑	81 ↓
Average cases per 4 hour session	2.3 ↓	2.8 ↓	2.0 ↓	2.1 ↓
Day Case Rate (Jan 2023)	74.8% ↓	85.1% ↑	76.0% ↓	74.1% ↑

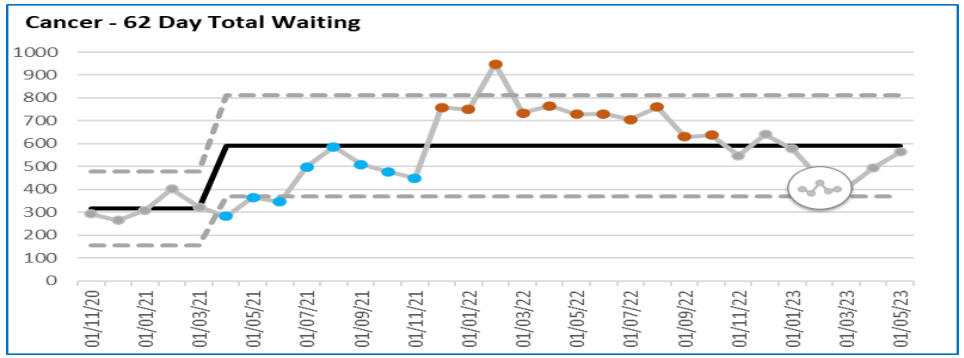
ICB Area	What the charts tell us	Issues	Actions
HWEICB	• Comparison of Model Health System theatre utilisation data from March 2023 and May 2023, rag rated against quartile performance.	• All trusts need to improve data quality and ensure data is captured at source and submitted in a standardised way • Further improvement is required to meet the operating plan guidance of 85% utilisation and 85% DC rates • Significant system variation in terms of day case rates and theatre utilisation, suggesting a significant productivity improvement opportunity	**GIRFT High Value Low Complexity Targets (HVLC):** 1. Theatres Capped Touch time Utilisation = 85% 2. BADS Day Case Rates = 85% • EoE Regional Improvement Manager has worked with PAH and is working with WHTH to ensure consistency of data capture and submission to model hospital. This work will now be extended to do the same with ENHT. The impact of this work will be seen in the data in future months. • EoE Region attended 6-4-2 meeting plus Theatre Improvement group in PAH. Areas discussed for improvement: Late starts (Urology big outlier), cases per list/utilisation in ophthalmology plus golden patient and standby patient process. Well attended and PAH theatre group looking at how data is used with clinicians and theatre staff to drive change. • The ICS Urology Clinical Network is focussing on improving day case rates for HVLC procedures • The ICS MSK Clinical Network is using learning from visits to Exeter's Surgical Hub to drive improvements in day case rates

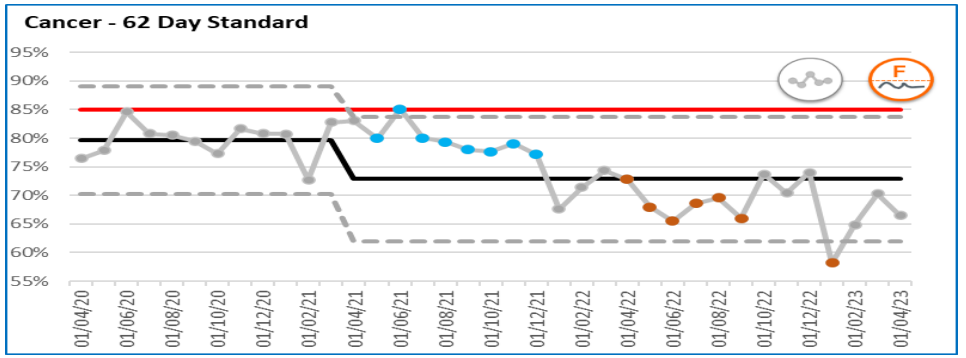
Cancer





	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	72.1%	73.6%	76.2%	78.7%	72.0%	71.8%	78.5%	74.8%	74.1%	64.2%	72.8%	74.6%	68.0%	64.2%	70.6%	71.7%	72.6%	69.7%	71.5%	71.7%	77.4%	65.8%	78.3%	72.9%	69.8%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	81.3%	79.8%	81.4%	82.1%	77.8%	77.2%	77.7%	71.9%	64.7%	67.0%	59.2%	54.6%	51.3%	57.7%	55.6%	60.3%	60.2%	57.8%	63.2%	71.3%	72.7%	70.1%	79.9%	78.6%	76.2%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	72.5%	74.6%	66.8%	77.1%	75.9%	62.8%	65.1%	60.6%	66.8%	50.9%	69.4%	69.3%	64.1%	65.9%	74.3%	72.3%	72.8%	68.3%	70.4%	73.7%	74.3%	72.2%	77.4%	78.5%	72.4%
ICS	75.6%	76.9%	75.4%	78.9%	75.3%	71.1%	73.8%	69.3%	68.8%	54.4%	67.3%	65.6%	60.8%	62.4%	66.4%	67.5%	68.3%	64.8%	68.0%	72.2%	74.7%	69.4%	78.0%	76.0%	72.8%





	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	73	76	96	105	79	83	109	88	132	179	130	128	129	331	347	374	307	261	297	297	277	270	257	233	195	191	184	129	125	148	127
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	129	118	200	187	127	107	141	161	212	224	201	190	127	175	176	303	194	182	156	128	125	162	152	163	149	193	182	153	120	148	213
EAST AND NORTH HERTFORDSHIRE NHS TRUST	90	70	120	106	117	92	114	96	155	184	178	160	193	253	226	272	232	322	275	306	304	329	221	242	203	256	211	170	160	199	224

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
EAST AND NORTH HERTFORDSHIRE NHS TRUST	87.3%	85.9%	87.2%	89.2%	85.3%	80.1%	86.8%	86.6%	87.0%	86.8%	85.4%	87.4%	81.1%	88.2%	85.0%	90.1%	86.1%	87.5%	86.1%	88.8%	86.2%	79.5%	87.6%	84.2%	86.0%	81.1%	82.4%	86.0%	82.6%	81.8%	80.7%	80.7%	81.0%	78.6%	81.8%	87.1%	83.8%
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	68.8%	73.8%	66.4%	74.7%	85.7%	82.7%	82.0%	83.1%	81.1%	83.1%	76.1%	75.4%	84.5%	84.8%	75.0%	86.8%	80.1%	79.8%	70.8%	75.0%	77.2%	75.1%	57.1%	62.5%	72.6%	60.2%	61.4%	56.1%	58.8%	59.8%	60.2%	68.7%	64.4%	69.5%	51.2%	58.8%	57.0%	64.7%
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	58.1%	63.1%	75.6%	75.0%	59.3%	66.3%	54.9%	67.3%	68.4%	65.4%	48.6%	68.3%	63.1%	68.8%	78.4%	56.1%	58.4%	69.8%	64.1%	52.5%	53.8%	47.7%	41.4%	58.1%	61.7%	48.2%	45.0%	44.8%	61.2%	31.9%	65.3%	55.7%	47.4%	32.1%	44.8%	51.8%	38.8%
ICS	78.5%	77.9%	84.6%	80.8%	80.6%	79.5%	77.5%	81.7%	80.8%	80.7%	72.7%	82.8%	83.1%	80.0%	85.1%	80.0%	79.3%	78.0%	77.7%	79.0%	77.2%	67.6%	71.4%	74.4%	72.8%	68.0%	69.5%	68.6%	68.8%	66.0%	73.7%	70.4%	74.0%	58.2%	64.8%	70.3%	66.5%

Cancer

ICB Area	What the charts tell us	Issues	Actions	Mitigation
ICB	• 2week wait referrals increased sharply in March but reduced again in April in line with the mean • 28 day Faster Diagnosis Standard performance declined in March and again in April • Performance declined for the number of patients waiting >62 days, which was 405 in March, 495 in April, and 564 in May. • Performance against the 62 day standard remains below standard with the treatment of the longest waiting patients, which after an improvement in both February and March, showed a decline in April	• 62 day performance remains non compliant • 62 day backlogs have increased at all three providers as a result of recent industrial action • Cancer patients were prioritised during the strikes, however, overall capacity was compromised. • WHTH are showing an Increased demand and insufficient capacity for diagnostics. • At WHTH patients over 104 days continues to decrease however, slow diagnostics, complex pathways and difficulty with patient engagement are slowing the whole pathway • At ENHT pressure areas are Urology and Lower GI with the largest backlogs • Endoscopy cancellations and patients delaying procedures have impacted Lower GI • ENHT: High volumes of inter-trust-referrals over 62 days • ENHT – high referral volumes during March in particular • ENHT - patients choosing to delay diagnostic element of pathway, especially Urology, H&N and Skin • PAH: Urology and Lower GI capacity and workforce	**PAH** • Majority of theatre lists, outpatients and MDTs maintained during June industrial action. Prioritisation and rebooking of the small number cancelled • Gynaecology tertiary patients at UCLH – additional surgeon appointed to tackle backlog and PAH Team attending UCLH ERG • Urology, Lower GI and Frailty Cancer Alliance bids for funding agreed in full – monies to flow from June / July • Continued recruitment to MDT tracker / coordinator roles – approaching full establishment • Super PTL days is in place to target booking and validation on a service by service basis • Ongoing demand / capacity / planning analysis across all tumour sites • Breast Pain Clinic pilot live. Volumes to increase with ESR rollout in July / August **WHTH** • Work continues on development on a Breast pain pathway along with plans to expand the multidisciplinary Breast Team • Plans for an additional Histopathology Consultant post, to support cancer diagnostic pathways • Patients tracked biweekly, escalation process in place and weekly huddle meetings for each tumour type to ensure early sight of issues and improve communication. • Performance reviewed in Access weekly meetings. All services are working on improvements • Cancer Improvement Steering Group established to provide oversight and additional resource for delivery of improvements. • Patient-level scrutiny for all long waiters during the weekly Cancer Long Waiters' meeting has resulted in a reduction in long waiters. Long Waiters Reviews now beginning at 40 days across all specialties. Stretch target (95) in place as NHSE target (143) already achieved • Plans in place for every patient >100 – service and clinical lead for each service to own these plans and will be monitored against these separately to reduce this number • Expanding NSS pathway to internal referrals to expedite the diagnosis of patients who have had site specific (e.g. GI) cancer excluded. **ENHT** • Trust has commenced pathway analysis with Intensive Support Team for Upper GI and Urology. This involves a detailed review of pathways in order to identify bottlenecks • Additional permanent endoscopy capacity on line at QEII and continuing to deliver WLI endoscopy sessions through June and beyond • Negative results letters / removal processes now in place although there were some delays recently due to bank holidays / IA	**PAH** • System support and oversight in place with bi-weekly meetings • New "real time" Cancer Harm Review process live • Safety netting in place to review any patient cohorts remaining on PTL inappropriately **WHTH** • All patients who are treated after Day 62 will be subject to a Clinical Harm Review • Clinical review is requested by MDT trackers as they track patients and escalated as necessary using new escalation process. Any patient found to have cancer will be subject to a clinical harm review after treatment. **ENHT** • In process of recruiting radiographers to staff LINAC machines following a period of high staff turnover • Seeking funding to replace obsolete LINAC machines which are less reliable than newer models

Performance v. 23/24 Operational Plans

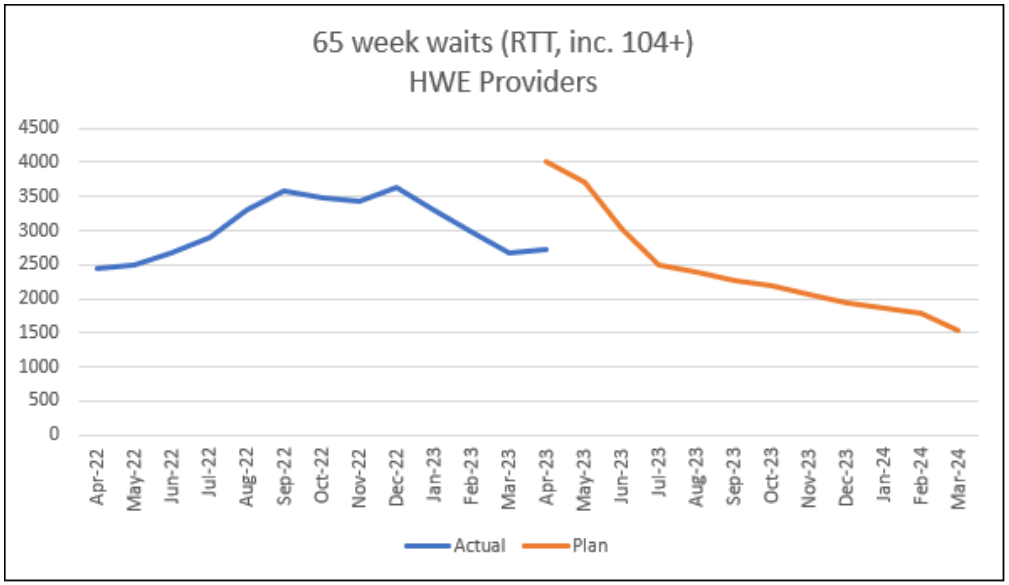
Herts and West Essex Providers (please see Appendix B for performance by Place)

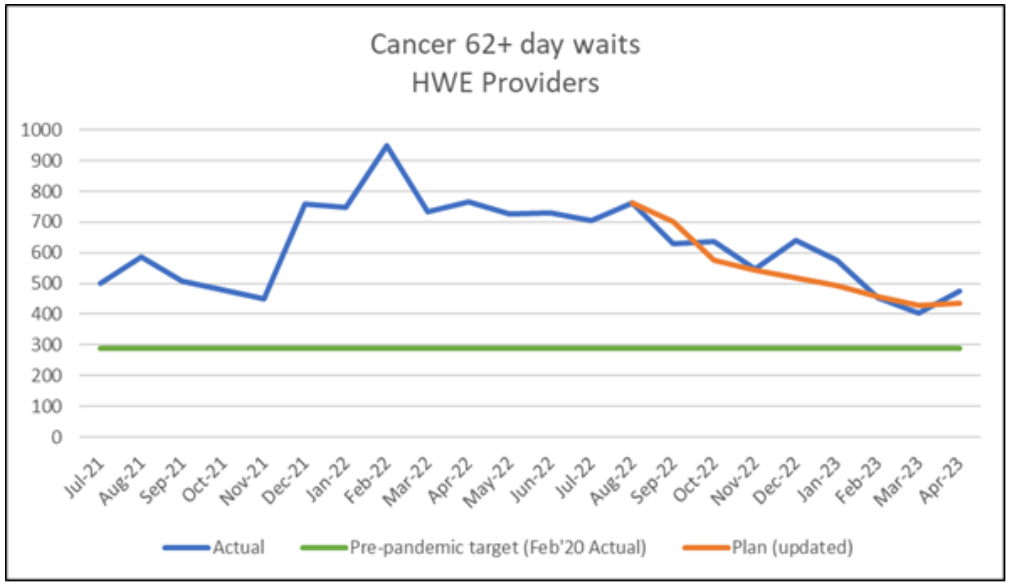
Baseline	23/24 Activity Plan	23/24 M1 Activity Plan	Area	Target		2023/24 Actual Apr	Status @ M1
306,136	281,386	21,517	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	21,517	Below plan
	-8%				Actual	16,997	
					Variance	-4,520	
N/A	0	0	Waitlist	Eliminate 104 week waits	Actual	3	Close to zero
N/A	1535	4012		Reduce 65 week waits	Actual	2709	Below plan
N/A	8860	11221		Reduce 52 week waits	Actual	9731	Below plan Higher than preceding months
640,054	588,367	45,297	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	45,297	Data tbc
	-8%				Actual	0	
					Variance	-45,297	
	1.2%	1.7%		5% of outpatients moved or discharged to RFU	Actual	1.4%	Below plan
				25% of consultations via video/telephone	Actual	26%	Meeting target (SUS data used at M01, to be revised)
				16 specialist advice requests per 100 outpatient firsts	Actual	4	M1 data incomplete
403,953	431,256	33,641	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	33,641	Below plan
	+7%				Actual	32,385	
					Variance	-1,256	
560	374	452	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	474	Above plan
69%	72%	69%		Reduction in missed 28 day cancer decisions	Actual	73%	Consistent with prior months

ICB Issues and escalations

- Elective activity is notably below plan in April and impacted by industrial action. Ongoing issue into May & June
- Diagnostics activity is also below plan and impacted by industrial action as above
- 28 Day Faster Diagnosis Standard (FDS) is just below the 75% national standard
- RTT and Cancer backlogs – see next slide
- Outpatient Follow-ups not updated as the revised provider feed for these was not agreed in time for Month 1
- System EROC data did not correctly uploaded for April, so the values for Specialist Advice are incorrect. This will correct when the revised data published at Month 2

Performance v. 23/24 Operational Plans

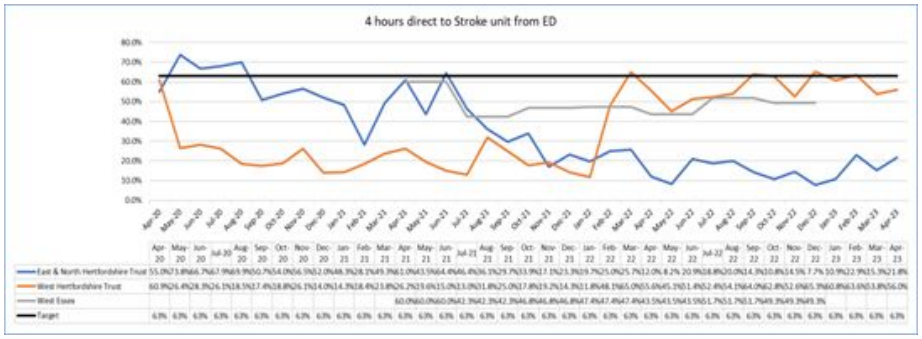


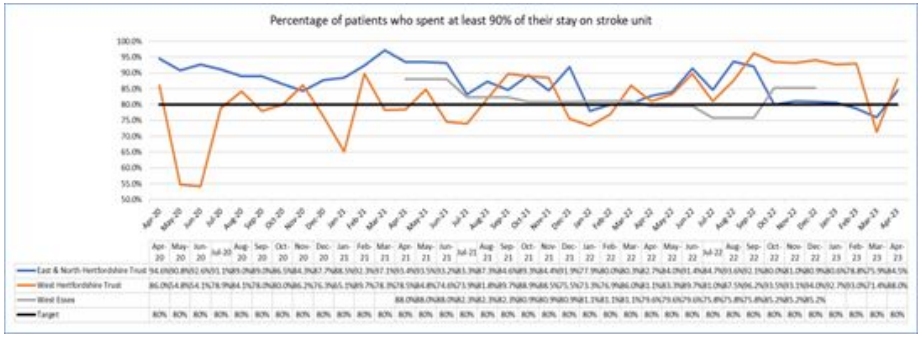


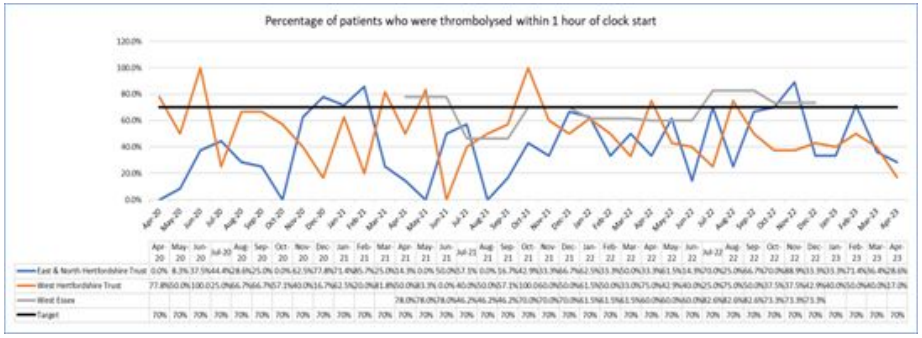
ICB Issues and escalations

- 65 week backlog recovery was ahead of plan in April. Local data for May / June suggests there has been no further improvement, and therefore performance is likely to have returned to trajectory by end of June
- Cancer 62 day backlog was above plan in April and has increased further in May / early June
- On-going impact to 65 week and 62 day recovery from Industrial Action

Stroke







ICB Issues, escalation and next steps

West Essex: Barking, Havering and Redbridge Trust (BHRT) is the main provider of Stroke for WE patients, reported quarterly via SSNAP. At the time of writing the full SSNAP data for Q4 is yet to be published

- BHRT overall Q4 SSNAP rating is C; Stroke Unit rating is E.
- My Personal Stroke Record pilot in Queens - feedback awaited
- Pre-hospital Stroke Video Assessment pilot: Ambulance crews suspecting a stroke can call a consultant directly via ipad to support the most appropriate / timely next steps. Project evaluation due August 23
- Stroke Association contract extended to March 25. Working with HCC re possible contract alignment
- ICB Squire bid £13K, 0.2wte successful for CLCH and HCT nominated staff to complete a gap analysis of community across the ICB. Outcomes received and ICB working with colleagues to agree priorities
- Catalyst funding bid £183K successful to pilot the implementation of vocational rehab. EPUT are the lead provider across the ICB. Patient engagement panel completed in June and recruitment underway

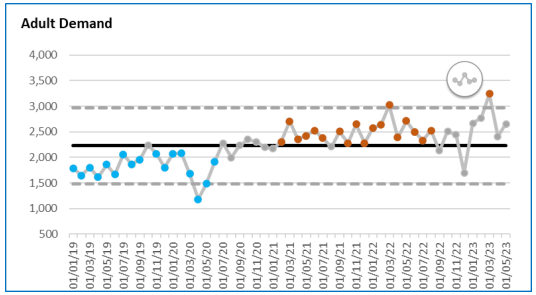
ENH

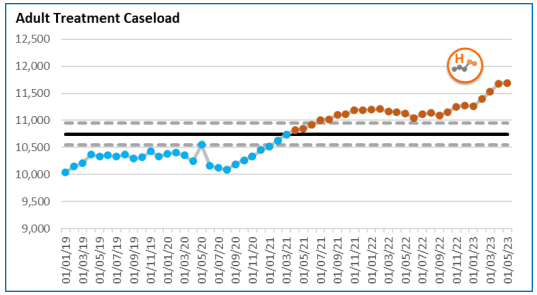
- The ENHT SSNAP performance for Jan-23 to Mar-23 remained as a D rating
- In Apr-23, ENHT met the 80% standard percentage of patients who spend 90% of their stay on a stroke unit
- Only 21.8% of patients met the 4 hours direct to stroke unit from ED target, primarily due to capacity and clerking delays. Improvements underway including a SOP to increase ringfencing of HASU capacity on Pirton
- Only 28.6% of patients were thrombolysed within 1 hour of clock start. EEAST and the stroke team are working to improve communication to support crews on site and awareness of patients attending ED
- A clinical audit for April on ambulance to arrival delays will be shared with EEAST and joint actions agreed
- April saw a decline in discharge standards, specifically the patient % screened for nutrition and seen by a dietician. Stroke team working with digital to improve process on NerveCentre and ward training is being undertaken

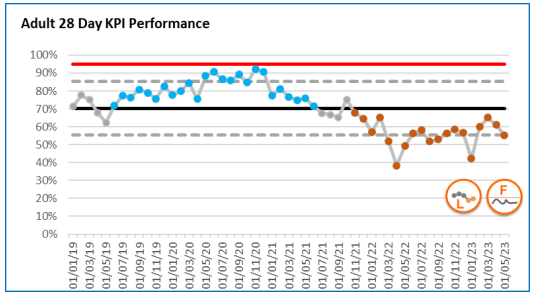
S&W Herts

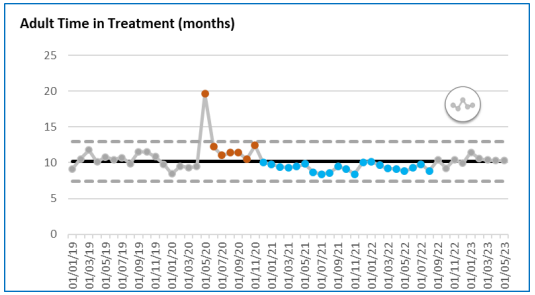
- SSNAP performance at WHTHT has fallen from an A rating to a B rating (Jan-March 2023) which is attributed to continued pressures on the system as a whole, ongoing challenges around patient flow and bed occupancy, and workforce challenges especially within the OT and SLT workforce
- Percentage of patients who spent at least 90% of their stay on a stroke unit continues to meet the 80% standard
- The % thrombolysed within 1 hour of clock start was not met in April with WHTH achieving 17% (Local target 50%). Stroke team and the clinical lead are reviewing the pathway for all to ascertain reasons for delays and to make improvements
- Performance remains below standard (90%) for 4 hours direct to stroke unit from ED. Pressures in flow within ED resulting in patients not being assessed immediately on arrival and wider system pressures have continued to impact. Patients receive stroke consultant input for their care while waiting for admission to the stroke unit
- ESD performance continues to be impacted by increased referrals and workforce issues, current wait times for ESD are between 7 and 10 days. Patients are contacted on referral, assessed, prioritised, and informed about how to access alternative support and self-manage while they are waiting to be seen.
- Rehabilitation Gym in WHTHT continues to be used as a bed occupancy surge area, which impacts gym usage
- Therapy teams at WHTH are meeting with ENHT to share 'good practice' around SSNAP Performance
- New Nurse Consultant post to be introduced as Medical Consultant vacancies remain. (1.5WTE vacant)

Mental Health – Adult Services



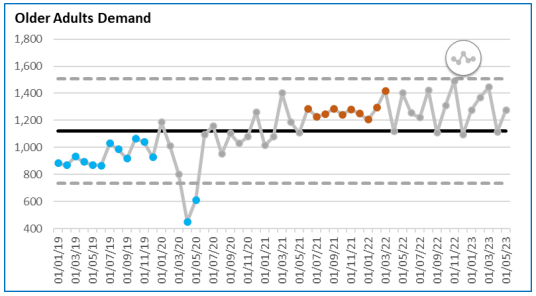


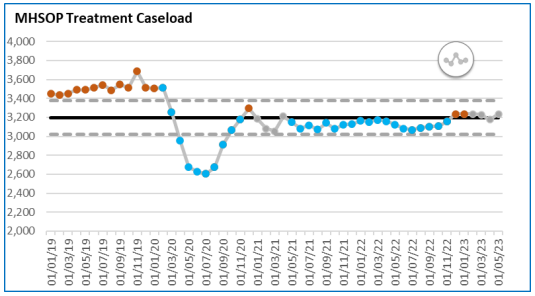


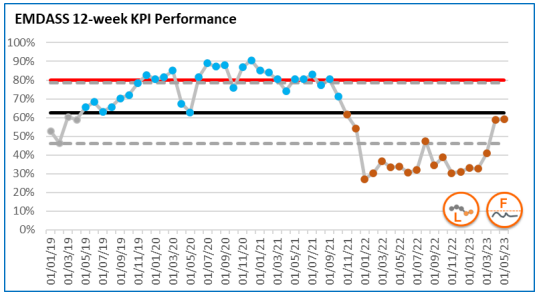


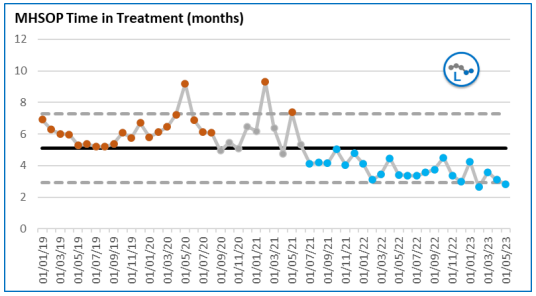
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Adult Community Mental Health Services	Referral demand remains high across the ICS. The caseload in community services continues to increase in Herts but remains stable in West Essex. The time it takes from referral to assessment has increased in line with high referral volumes and caseloads in Herts and the target for carrying out assessments within 28 days of referral is not met. EPUT continue to meet the 28 day KPI. Overall time spent on treatment pathways remains stable.	Across the ICS, sustained high demand continues, impacting on waiting lists for initial assessments in Herts. Despite good recovery in other parts of Herts, recovery in southwest quadrant is delayed due to significant issues in recruiting to vacancies and increased demand. Increased referrals for adult ADHD diagnosis impacting on capacity.	Additional assessments slots being provided weekly, including out of hours clinics. Workforce implementation group set up with focus on recruitment and retention. Additional administrative support to community mental health teams in Herts. Demand and capacity review being undertaken in Herts as part of the community transformation programme. HPFT is implementing digital solution to support initial assessments.	Robust waiting list management and risk management protocols in place with daily and weekly reviews. Equality review of waiting list carried out in Herts, work to be shared across the system. Recovery of performance in the Herts southwest quadrant is expected in Quarter 3, however, increased referrals present a risk to recovery.

Mental Health – Older Adults Services



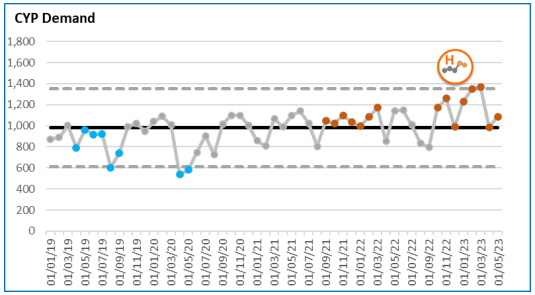


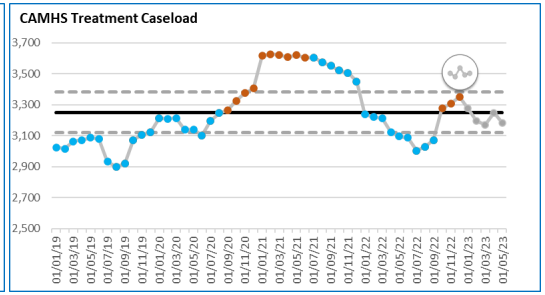


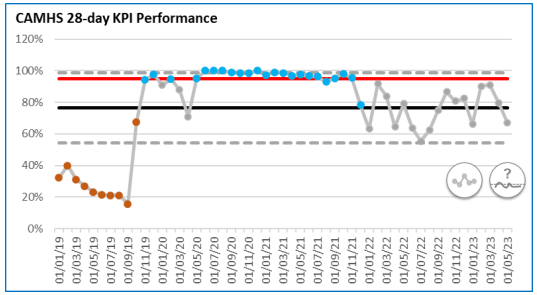


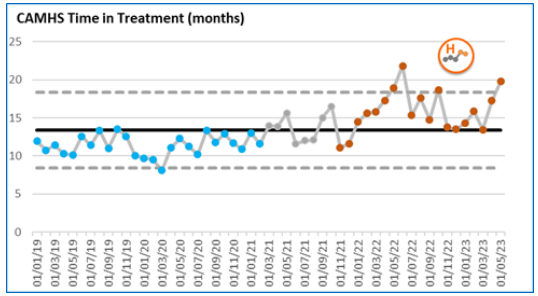
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Older Adult Community Mental Health Services	Increased demand continues across the ICS. Caseloads continue to be stable. Hertfordshire performance against 12 week contract performance remains below target in Herts, but West Essex continues to meet 6 week to diagnosis appointment ambition. Overall time spent on treatment pathways has improved.	In Herts pressure from the backlog of diagnosis continues. Recruitment vacancies continue to be a significant issue across the ICS.	Recovery programme continues with weekly planning meetings in Herts. Workforce implementation Group set up with focus on recruitment and retention. Dementia nurses in primary care model (aligned to PCNs) to improve diagnosis. West Essex and Herts working to share best practice. Future expansion of community diagnostic capacity across ICB.	Risk review and prioritisation for service users who have been waiting. Additional clinics for evening and weekends to improve waiting times. Herts EMDASS recovery expected in Q3 2023/24 remains on track.

Mental Health – CAMHS Services



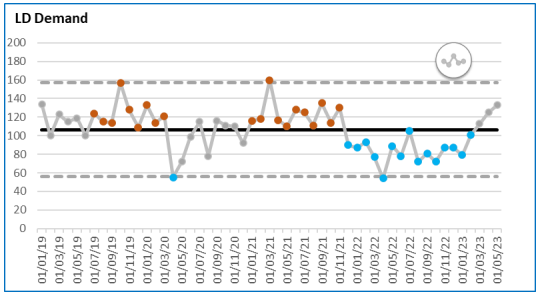


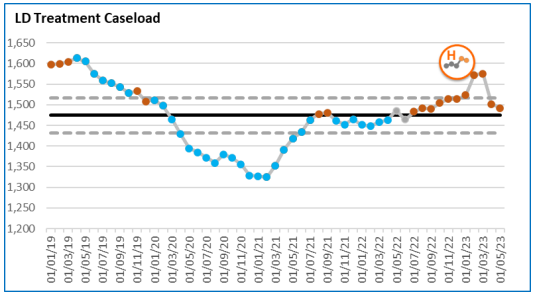


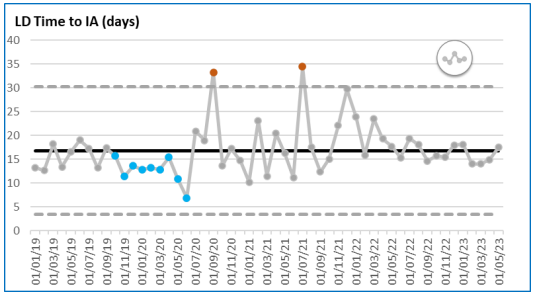


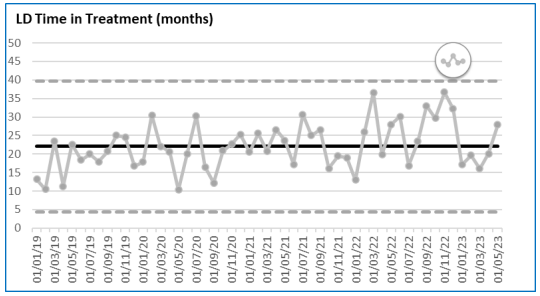
ICB Area	What the charts tell us	Issues	Actions	Mitigation
CAMHS HPFT data only for CAMHS 28 day Time in Treatment KPIs. Information is not captured in West Essex	Received referrals into CAMHS single point of access during February and March have been high, April and May have seen a reduction. There has been a drop in the Herts achievement of the 28 Day KPI performance metric. From Jan 2023 Herts have not met the performance KPI for initial assessments (Choice). Length of time from referral to discharge has grown by 3 months over the last year from a mean of 12 months to 15 months. However, there has been an improvement over the last 5 months from a peak of 17+ months.	Some services in West Essex & Hertfordshire have seen unexpected demand (e.g. Specialist CAMHS ED, Crisis, and Children Looked After) in recent months. Active issue regarding recruitment to vacancies across Herts and West Essex impacting on capacity and performance.	Recovery programmes in place for CAMHS, with weekly review meetings for demand and capacity. Ongoing focus on recruitment and retention in both HPFT/NELFT; including recruitment incentives (NELFT).	SPA Triage Tool improved to meet 5 day pass on to teams target. Ongoing job planning in all quadrants to ensure qualitative approach. Caseload and resource management across quadrants to support areas under pressure. Hertfordshire recovery for referral to assessment times to 28 days expected at the end of Q2 2023/24. However the ability to recruit to vacancies continues to present a risk to recovery.

Mental Health – Learning Disabilities Services



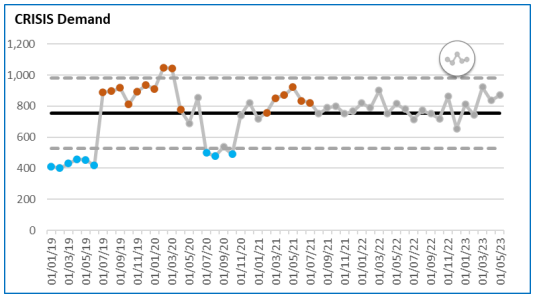


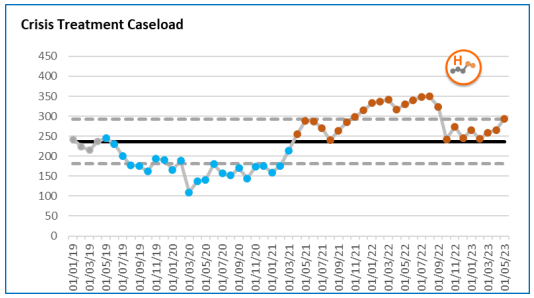


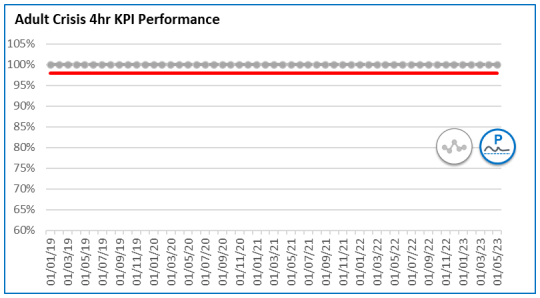


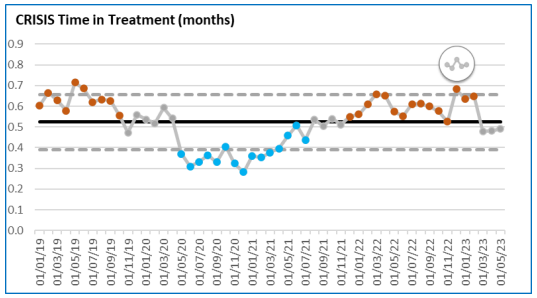
ICB Area	What the charts tell us	Issues	Actions	Mitigation
Learning Disabilities Service Herts only	Referrals and caseloads services remain stable. Service Users are seen consistently within 28 days of referral. Time in treatment is subject to common cause variance. Within the LD&F Care Group there is a wide range of treatment times ranging from many years to a few days.	Frailty is very clear area of focus for our LD care group based on the outcome of LeDeR reviews and findings.	Service user and carer engagement and involvement programme continues aimed at improving care planning, service delivery and outcomes for LD service users across Herts and Essex. Enhanced physical health clinics, health co-ordination and frailty.	Continuing work with commissioners to ensure that GPs are aware and know how to refer directly into LD services.

Mental Health – Crisis Services



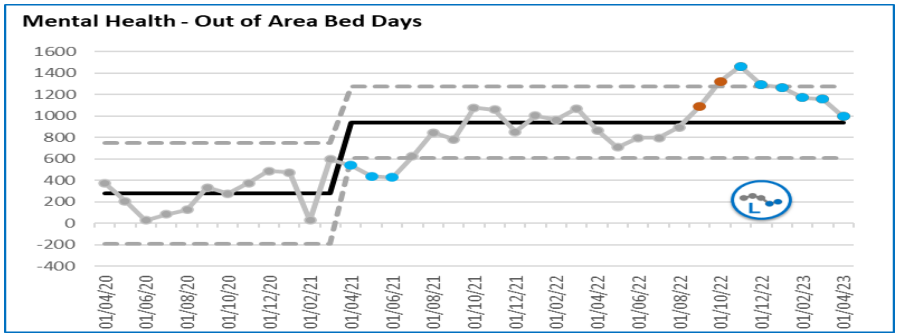




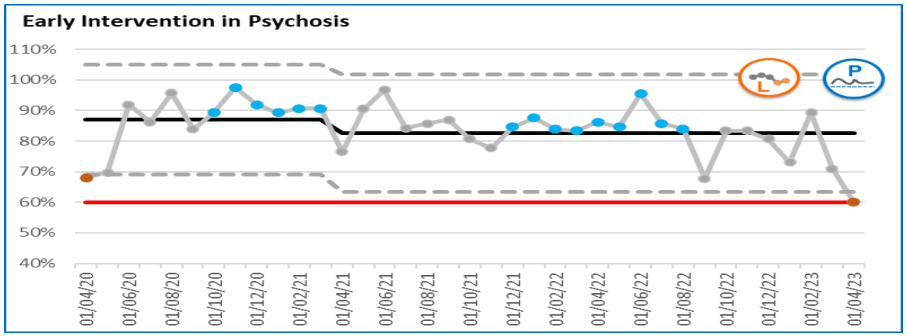


ICB Area	What the charts tell us	Issues	Actions	Mitigation
Crisis Services – Adults and Older Adults West Essex caseloads currently not included in charts (part of Home Treatment Team, however collation of data is being reviewed	Crisis demand is high against historical baselines, but remains stable. Caseloads are high against historical baselines which reflects an increase in case complexity. Service Users are seen consistently within 4 hours of referral. The average time under caseload management in the Crisis and Home Treatment Team is 1 month.	Recruitment to vacancies continues to be a significant issue across the ICS. HPFT crisis teams continue to use a manual process for monitoring of and reporting on response times.	Ongoing focus on recruitment to vacancies and retention of existing staff. Development and implementation of a digital solution in HPFT to improve efficiency and quality of the reporting in Quarter 2.	Continue to identify DTCs on crisis caseload. Ongoing monitoring and MDT discussion to identify treatment pathway, discharge plan and PDDs.

Mental Health – Out of Area Bed Days and Early Intervention in Psychosis (EIP)



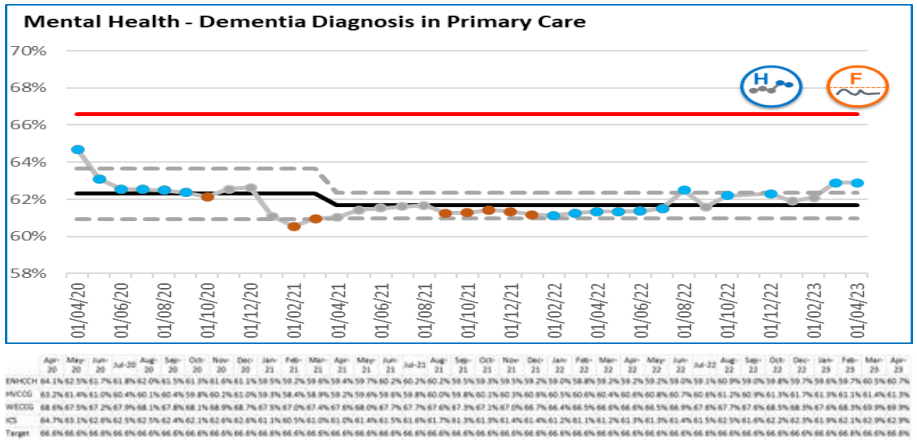
	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Hertfordshire	372	207	26	83	125	331	277	376	486	471	26	596	452	337	336	574	834	759	936	745	674	779	830	987	767	691	775	757	817	1034	1177	1221	1080	1062	1003	966	650
Hertfordshire Target	33	33	34	20	20	20	10	10	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
WECCG													86	102	90	51	12	22	140	314	177	225	154	83	100	16	21	38	76	55	145	242	209	203	166	191	145



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
ENHCCG	100.0	91.7%	100.0	91.7%	100.0	80.0%	80.0%	100.0	100.0	91.7%	94.7%	93.8%	81.3%	88.9%	91.7%	85.7%	80.0%	100.0	88.9%	71.4%	72.7%	87.5%	87.5%	92.9%	87.5%	100.0	87.5%	93.8%	75.0%	50.0%	83.3%	90.0%	60.0%	75.0%	57.1%	71.4%	70.0%
HVCCG	52.9%	60.0%	90.0%	85.7%	100.0	81.3%	100.0	95.0%	81.3%	85.7%	81.8%	90.0%	75.0%	100.0	100.0	75.0%	87.5%	80.0%	91.7%	83.3%	88.9%	90.0%	78.6%	66.7%	80.0%	70.0%	100.0	75.0%	100.0	58.3%	81.8%	75.0%	77.8%	63.6%	100.0	66.7%	46.2%
WECCG	100.0	50.0%	83.3%	66.7%	85.7%	90.0%	80.0%	100.0	100.0	100.0	100.0	83.3%	66.7%	66.7%	100.0	87.5%	87.5%	80.0%	60.0%	85.7%	100.0	83.3%	88.9%	85.7%	90.9%	88.9%	100.0	75.0%	80.0%	100.0	100.0	83.3%	100.0	100.0	100.0	91.5%	100.0
ICS	68.0%	69.7%	91.9%	86.2%	95.7%	83.9%	89.3%	97.6%	91.9%	89.3%	90.6%	90.6%	76.5%	90.5%	96.7%	84.2%	85.7%	87.0%	80.6%	77.8%	84.6%	87.5%	83.9%	83.3%	86.2%	84.6%	95.5%	85.7%	84.0%	67.7%	83.3%	83.3%	80.6%	73.1%	89.3%	71.0%	60.0%

ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex	• Trend of continued improvement since November • April beds days improved for the fifth consecutive month	• A national shortage of MH beds and use of OOA beds is likely to continue	• Review of Essex bed stock continues with system partners • Further development of the new Accommodation Pathway contract • Review of West Essex Community Rehab requirements	• Out of Area Placement (OOAP) Elimination & Sustainability Impact System Group (Essex wide) in place to monitor the impact of the NHSE OOAP Action Plan • Continued engagement with national Getting It Right First Time (GIRFT) programme to identify areas of improvement • Bed management system and new arrangements in place to monitor demand and capacity
Herts	• Out of Area Bed Days continue to reduce from the peak in November 22	• Demand continue to exceed capacity. • Low number of beds per population. • A national shortage of MH beds, high occupancy rates and use of OOA beds is likely to continue • Challenges finding suitable placements for service users with complex needs • IP and Community recruitment	• Daily OOAP reviews /dedicated clinical ownership for OAP • Gatekeeping process; on call gatekeeping consultant and clear reasons for admissions • Introduction of Enhanced Discharge Team, dedicated to supporting discharge pathways • Multi Agency Discharge Event (MADE) in January highlight issues, review DTCs and plan discharges with ongoing regular MADE events • Block beds in place to improve flow across the system • Enhanced community offers for rehab and assertive outreach. • Introducing further alternatives to admission – Crisis House	
EIP	• The EIP national standard was achieved in ENH and WE, however performance dipped significantly in April in SWH	• SWH performance in April due to unplanned staff absence	• Ongoing monitoring	• Consistently compliant standard. SWH performance was recovered to 67% in May

Mental Health – Dementia Diagnosis in Primary Care & Learning Disability Health Checks

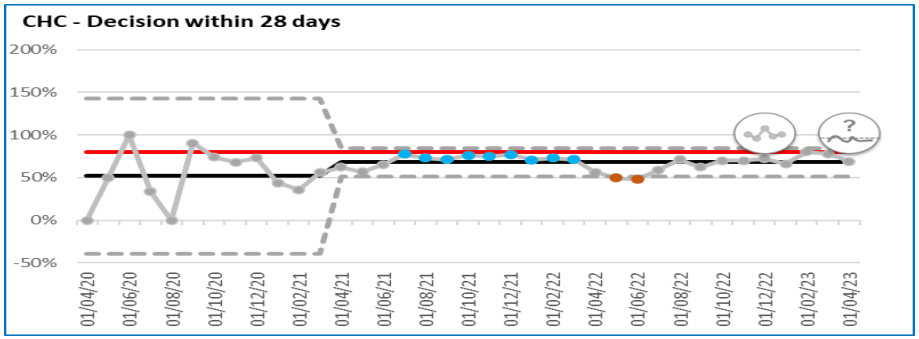


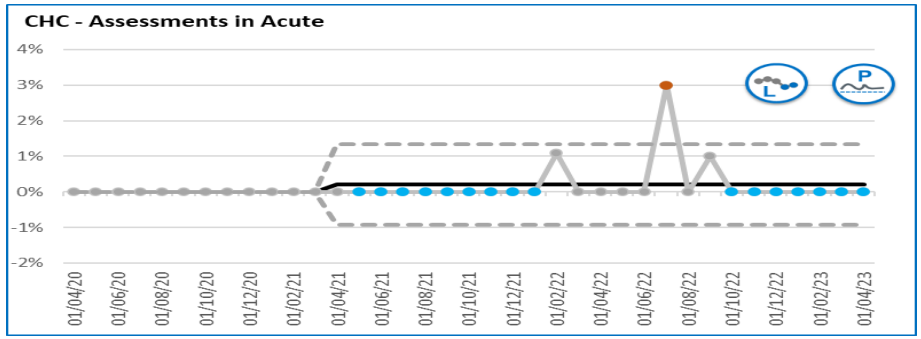
2022/23 LD Health Checks	Total LD Register (age 14+)	Completed health checks	Health Checks Declined	Patients NOT had a health check	% Completed health checks
NHS Hertfordshire and West Essex ICB	**7,185**	**5,682**	**319**	**1,184**	**79.1%**
East & North Hertfordshire	2,958	2,224	113	621	**75.2%**
South & West Hertfordshire	3,184	2,633	128	423	**82.7%**
West Essex	1,043	825	78	140	**79.1%**

HWE ICB, as well as all three Places, successfully achieved the 75% national standard in 2022/23

ICB Area	What the charts tell us	Issues	Actions	Mitigation
Dementia Diagnosis in Primary Care	• Recorded Dementia Diagnosis in Primary Care in January 2023 for Hertfordshire improved to 59.95%, although remains below standard. The estimated population numbers for Hertfordshire changed in the national data collection for these publications. A total of 868 people are required to meet the target • West Essex is achieving the national target with 69.9% achieved	**Dementia Diagnosis Herts** • In Hertfordshire demand is high and the number of people on the EMDASS waiting list remains high in April at 664. This has improved as in January it was 761. • Conversion rate and triage – patients are referred to EMDASS and not diagnosed with dementia. • Only 50% EMDASS are seen within 12 weeks (80% target) • Not enough focus on diagnosis in primary care. • Commissioners continuing to follow up to get Practice Data to review monthly in order to offer support to the poor performing practises.	**Dementia Diagnosis Herts:** • Recovery action plan agreed with actions commencing in January 2023 • Staffing: Now fully recruited to the total number of four Dementia Specialist Nurses, who are working at the Primary Care Networks, and focusing on the over 80s • Conversion rate is improving at 61% with the support of region • Framework (ECF) for GPs to complete coding exercise to capture true diagnosis rate • Admin role in Primary Care Diagnosis Service to free Nurse Specialists	**Herts:** • Dementia Diagnosis actions will deliver recovery to trajectory by 2023/24 • Bring Recovery Action Plans into one forum to ensure central oversight • Ongoing support to identify causes of low conversion rates at memory clinics

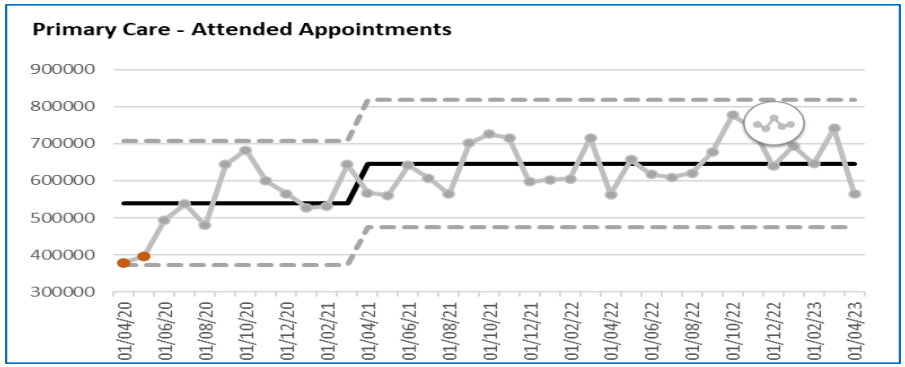
Continuing Health Care (CHC)

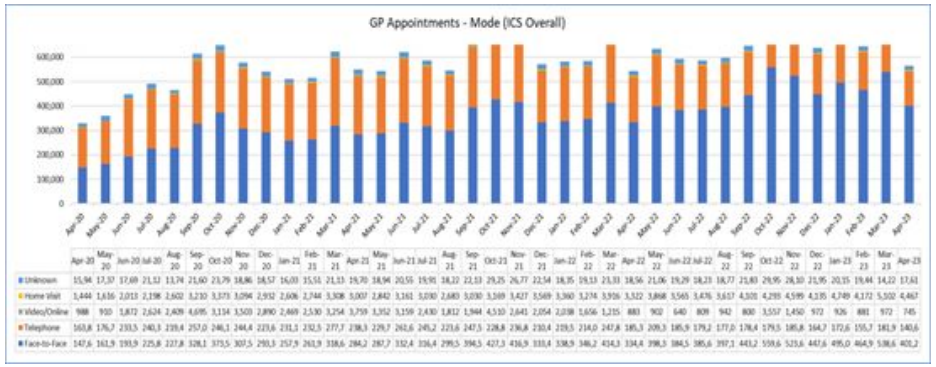




ICB Area	What the charts tell us	Issues	Actions	Mitigation
West Essex / PAH	• Continued compliance with the 28 day assessment standard • Zero assessments in an acute setting	• Ongoing increasing backlog of CHC, FT and FNC reviews due to prioritising new assessments and D2As. New reviews project paused due to number of D2A assessments coming through. New nurse has started and will help with this backlog as they become more confident	• The West Essex CHC Team continues to work alongside EPUT to provide additional resource and support. • Mentorship for new staff in role • Weekly tracking of 28 day assessment ongoing. EPUT full engaged with this process	• SWH action plan in place, supported by NHSE • Performance standards continue to be monitored, issues escalated and risks mitigated • Agency cover requested for vacancies whilst recruitment continues • Setting trajectory and drive on clearing cases over 28 days
South West Herts / WHTHT	• Performance against decisions within 28 days was not met in May at 62% • Zero assessments in an acute setting	• Workforce issues continue with a high number of vacancies. 3 new Band 6 nurses are expected to start by July • Ongoing backlog of CHC & FNC reviews due to prioritising new DSTs and checklist completion • Referrals numbers continue to be high which impact on 28 day performance	• Ongoing recruitment and prioritisation of fast track and 1:1 reviews • Allocation and weekly tracking of 28 day assessments remains a priority • Case management in place for all cases over 6 weeks • Collaborative working with system partners; weekly meetings • Timely decision making panels, verification & monitoring of recommendations • Focus on checklist completion, resulting in backlog reducing	
East & North Herts / ENHT	• 28 day standard achieved at 86% • Zero assessments in an acute setting	• Workforce issues such as sickness and annual leave • Ongoing delays receiving signed assessment paperwork from community, particularly Mental Health, may impact performance going forward	• Weekly tracking of referrals over 28 days by caseload and CHC manager • 28 day case backlog reducing- expected to meet target by end of quarter	

Primary Care





ICB Area	What the charts tell us	Issues	Actions	Mitigation

ICB	• Total appointments were less in April, but this likely reflects seasonality
	• The proportion of face to face appointments is steady at just over 70% since Q3 2022/23. There is however variation at practice level
	• Data does not include appointments delivered at hub sites as part of Extended Access
		• General Practice continues to see increases in demand against a backdrop of working through the backlog, workforce pressures and negative media portrayal
		• Significant pressure from Respiratory illness
		• Rapid increase in 'spot booking' hotels set up without notice by Home Office to house asylum seekers with significant health needs, including Scabies and Diphtheria outbreaks
			• National repurposing of Investment & Impact Funds. Template for plans shared with PCNs for return to ICB 12/5
			• Data sets shared with practices/PCNs via Ardens and developing patient questionnaires to support analysis
			• Continue to implement offsite storage of notes
			• Access dashboard now available and used by MDT group
			• Offer of 3m extension for to achieve QOF targets to recognise prioritisation of on the day demand over winter
			• Engagement with the National Access Recovery Plan including:
			• Cloud Based Telephony transition support – 28 practices identified as high priority as still using analogue systems
			• National GP Improvement Programme (NGPIP)
			  ○ Webinars re 5 key priority areas. Advice on making practical changes and improvements in general practice
			  ○ Intermediate/Intensive/Hands On facilitated support. Place teams encouraging practice & PCN engagement
			  ○ Care navigation training: each practice can nominate one member of staff for training – details awaited
			• Support Level Framework (SLF)
			  ○ Self assessment tool delivered through a facilitated conversation with members of the practice team to support in gaining an understanding of what they do well, what they might wish to do better, and where they might benefit from development support. Aim for all practices to have had a facilitated discussion using the SLF during the year
			• Transformation support funding
			  ○ Indicative £13.5k per qualifying practice. Final guidance awaited, but likely to be very specific to support practices 'seeking to implement Modern General Practice Access model'. Temp to support to clear appt. books pre-transition
			• Other
			  ○ Comms. to support ICB and practice websites, media statements and patient comms re the Delivery Plan
			  ○ Attendance at NHSE regional weekly drop-in sessions to escalate any issues or questions for clarification
				• Support return to business as usual to General Practice via relaunch of the ECF across the ICB
				• Investment reporting to free up practice capacity
				• QOF period extension means that some annual review actions for LTC will be reprofiled to spring and should have a benefit next winter
				• Trend analysis to identify individual practices with poor access via complaints and patient contacts
				• PCCC and Primary Care Board oversight of the GPPS results, and action plan developed through the Access MDT Group
				• Recruitment & Retention of Primary Care Workforce. Initiatives for Primary Care Workforce to support recruitment and retention which are supported by the HSE ICB Training Hub
				• Continued funding for spot booking hotels for health checks and MDT site visits agreed by PCCC at the February meeting
				• Daily review of OPEL reporting by practices and follow up by place Primary Care Teams with individual practices continuing
				• Continued work to promote use of the Community Pharmacy Consultation Service (CPCS)

Appendix A – Performance Dashboard

April 2023

Area	Activity	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *1	Variation	Assurance	NATIONAL position (ICB vs National)	REGIONAL position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	Individual Trust ENHT	Trend	PAH	Trend	WHTHT	Trend
111	Calls answered < 60 seconds	95%	51.1%	April 23	✓ 20.00%			56.74% (Worse)	46.08% (Better)	15th lowest	51.1%	✓ 20.00%						
	Calls abandoned after 30 seconds	5%	10.3%	April 23	✓ -29.60%			10.19% (Better)	12.99% (Better)	15th highest	10.32%	✓ -29.60%						
A&E	% Seen within 4 hours	76%	68.2%	May 23	✓ 0.589%			73.96% (Worse)	70.1% (Worse)	6th lowest	65.53%	✓ 0.41%	64.98%	✗ -1.55%	53.02%	✗ -3.40%	74.14%	✓ 3.67%
	12 Hour Breaches	0	134	May 23	✗ 58.96%			31,494	1,972	8th highest	134	✗ 58.96%	35	✗ 22.86%	99	✗ 71.72%	0	– 0.00%
Cancer	2ww All Cancer	93%	77.2%	April 23	✗ -11.44%			77.71% (Worse)	71.38% (Better)	23rd highest	76.27%	✗ -13.98%	92.48%	✗ -2.92%	59.15%	✗ -29.84%	73.98%	✗ -17.48%
	2ww Breast Symptoms	93%	77.9%	April 23	✗ -2.49%			72.19% (Better)	65.89% (Better)	19th highest	78.54%	✗ -1.53%	91.03%	✗ -3.33%	65.88%	✗ -4.08%	79.59%	✓ 3.08%
	31 day First	96%	92.9%	April 23	✗ -2.87%			90.48% (Better)	90.08% (Better)	15th highest	95.52%	✗ -1.52%	95.96%	✗ -0.94%	93.67%	✗ -0.15%	96.00%	✗ -3.44%
	31 day Sub Surgery	94%	82.6%	April 23	✗ -7.67%			76.78% (Better)	73.06% (Better)	11th highest	84.48%	✗ -8.50%	84.38%	✗ -10.34%	70.00%	✓ 4.76%	93.75%	✗ -2.40%
	31 day Sub Drug	98%	100.0%	April 23	✓ 1.87%			97.37% (Better)	98.03% (Better)	10th highest	100%	✓ 0.82%	100%	– 0.00%	100%	✓ 5.41%	100%	– 0.00%
	31 day Sub Radiotherapy	94%	73.2%	April 23	✗ -21.76%			86.32% (Worse)	86.31% (Worse)	9th lowest	65.57%	✗ -32.33%	65.57%	✗ -32.33%	N/A		N/A	
	62 day First	85%	62.1%	April 23	✗ -5.74%			61.04% (Better)	57.23% (Better)	19th highest	66.52%	✗ -5.67%	83.76%	✗ -3.97%	38.94%	✗ -33.00%	64.74%	✓ 11.98%
	62 day Screening	90%	74.2%	April 23	✓ 0.51%			67.82% (Better)	73.96% (Better)	12th highest	81.25%	✓ 9.94%	100%	– 0.00%	62%	✓ 45.83%	90.91%	✓ 10.63%
	62 day Upgrade	85%	65.6%	April 23	✗ -3.41%			74.44% (Worse)	72.24% (Worse)	11th lowest	64.42%	✗ -13.76%	83.78%	✓ 7.44%	47.83%	✗ -48.11%	66.67%	✗ -8.00%
	28 days Faster Diagnosis	75%	72.3%	April 23	✗ -3.55%			71.35% (Better)	67.94% (Better)	16th highest	72.86%	✗ -4.35%	69.78%	✗ -4.42%	72.38%	✗ -5.67%	76.03%	✗ -3.38%
RTT	Incomplete Pathways <18 weeks	92%	55.9%	April 23	✗ -1.68%			58.3% (Worse)	55.2% (Better)	14th lowest	52.26%	✗ -1.92%	48.47%	✗ -2.82%	51.88%	✓ 0.87%	56.61%	✗ -2.78%
	52 weeks	0	12,141	April 23	✗ 7.87%			371,111	54,182	6th lowest	9,721	✗ 3.46%	5,061	✗ 5.28%	1,973	✗ 5.22%	2,687	✓ -1.27%
	65 weeks	0	3,354	April 23	✗ 5.84%			95,135	13,779	8th lowest	2,707	✗ 7.02%	1,609	✗ 7.15%	604	✗ 14.57%	494	✓ -2.63%
	78 weeks	0	521	April 23	✗ 7.10%			11,477	1,558	5th lowest	494	✗ 12.15%	460	✗ 11.96%	23	✗ 39.13%	11	✓ -36.36%
Diagnostics	6 week wait	5%	32.9%	April 23	✗ 4.24%			27.6% (Worse)	31.0% (Worse)	15th lowest	37.44%	✗ 4.69%	45.26%	✗ 7.32%	25.14%	✗ 6.22%	36.20%	✓ -2.04%

Area	Metric	Target	Herts & West Essex ICS (Commissioner) Latest published data	Data published	Trend *	Variation	Assurance	National position (ICB vs National)	Regional position (ICB vs EoE Region)	ICB Ranking	ICS Aggregate Provider	Trend	Individual CCGs East & North Herts	Trend	South & West Herts	Trend	West Essex	Trend
111	Calls answered < 60 seconds	95%	51.1%	April 23	✓ 20.00%			56.74% (Worse)	46.08% (Better)	15th lowest	N/A		51.51%	✓ 20.00%			49.31%	✓ 20.11%
	Calls abandoned after 30 seconds	5%	10.3%	April 23	✓ -29.60%			10.19% (Better)	12.99% (Better)	15th highest			10.16%	✓ -28.29%			10.93%	✓ -34.70%
Mental Health	Dementia Diagnosis rate	66.6%	62.9%	May 23	✓ 0.06%			63.1% (Worse)	60.8% (Better)	19th lowest			60.70%	✓ 0.06%	61.30%	✓ 0.04%	70.00%	✓ 0.11%
	OOA placements	0	995	April 23	✓ -16.28%			n/a	n/a	n/a			650	✓ -48.62%			345	✗ 44.64%
CHC	% of eligibility decisions made within 28 days	80%	68.9%	April 23	✗ -12.67%			n/a	n/a	n/a			82.50%	✗ -5.74%	50.00%	✗ -34.15%	91.67%	✓ 3.03%
	% of assessments carried out in acute	15%	0.0%	April 23	– 0.00%			n/a	n/a	n/a			0%	– 0.00%	0%	– 0.00%	0%	– 0.00%

LEGEND On/above target | Below target | ✓ Improvement on previous month's performance | ✗ Decrease on previous month's performance | – No change on previous month's performance

Appendix B: Performance v. 23/24 Operational Plans by Place

East and North Herts Trust

Baseline	23/24 Activity Plan	23/24 M1 Activity Plan	Area	Target		2023/24 Actual Apr	Status @ M1
132,182	106,624	7,738	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	7,738	Below plan
	-19%				Actual	7,282	
					Variance	-456	
N/A	N/A	N/A	Waitlist	Eliminate 104 week waits	Actual	0	At Zero
N/A	1,535	2,658		Reduce 65 week waits	Actual	1610	Below plan
N/A	5,951	6,681		Reduce 52 week waits	Actual	5064	Below plan
327,739	325,028	24,103	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	24,103	Data tbc
	-1%				Actual	0	
					Variance	-24,103	
	1.9%	2.0%		5% of outpatients moved or discharged to RFU	Actual	1.4%	Below plan
				25% of consultations via video/telephone	Actual	25%	Meeting target (SUS data used at M01, to be revised)
				16 specialist advice requests per 100 outpatient firsts	Actual	5	M1 data incomplete
180,440	181,580	13,173	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	13,173	Activity close to plan
	+1%				Actual	13,122	
					Variance	-51	
200	149.75	168	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	127	Below plan
72%	71%	69%		Reduction in missed 28 day cancer decisions	Actual	70%	Consistent with prior months

Appendix B: Performance v. 23/24 Operational Plans by Place

PAH

Baseline	23/24 Activity Plan	23/24 M1 Activity Plan	Area	Target		2023/24 Actual Apr	Status @ M1
69,186	69,492	5,791	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	5,791	Below plan
	+0%				Actual	4,676	
					Variance	-1,115	
N/A	N/A	N/A	Waitlist	Eliminate 104 week waits	Actual	2	Close to zero
N/A	0	603		Reduce 65 week waits	Actual	604	At plan
N/A	865	1,745		Reduce 52 week waits	Actual	1973	Above plan
122,435	127,467	10,278	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	10,278	Data tbc
	+4%				Actual	0	
					Variance	-10,278	
	1.2%	1.6%		5% of outpatients moved or discharged to PIFU	Actual	1.3%	Below plan
				25% of consultations via video/telephone	Actual	32%	Exceeding target (SUS data used at M01, to be revised)
				16 specialist advice requests per 100 outpatient firsts	Actual	1	M1 data incomplete
116,952	122,967	9,375	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	9,375	Activity close to plan
	+5%				Actual	9,287	
					Variance	-88	
145	116.92	142	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	148	Above plan
72%	75%	74%		Reduction in missed 28 day cancer decisions	Actual	72%	Consistent with prior months

Appendix B: Performance v. 23/24 Operational Plans by Place

West Herts Teaching Hospitals Trust

Baseline	23/24 Activity Plan	23/24 M1 Activity Plan	Area	Target		2023/24 Actual Apr	Status @ M1
104,768	105,270 +0%	7,988	Activity	10% elective activity increase (19/20 levels RTT pathway)	Plan	7,988	Below plan
					Actual	5,039	
					Variance	-2,949	
N/A	N/A	N/A	Waitlist	Eliminate 104 week waits	Actual	1	Close to zero
N/A	0	751		Reduce 65 week waits	Actual	495	Below plan
N/A	2,044	2,795		Reduce 52 week waits	Actual	2694	Below plan
189,879	135,872 -28%	10,916	Outpatients	25% reduction in outpatient follow-ups by 2023	Plan	10,916	Data tbc
					Actual	0	
					Variance	-10,916	
	0.8%	1.4%		5% of outpatients moved or discharged to PIFU	Actual	1.8%	Above plan
				25% of consultations via video/telephone	Actual	20%	Approaching target (SUS data used at M01, to be revised)
				16 specialist advice requests per 100 outpatient firsts	Actual	6	M1 data incomplete
106,561	126,709 +19%	11,093	Diagnostics	20% increase in diagnostic capacity against 19/20 levels	Plan	11,093	Below plan
					Actual	9,976	
					Variance	-1,117	
215	107.33	142	Cancer	Reducing cancer 62+ day waitlist to pre-pandemic levels	Actual	199	Above plan
71%	70%	65%		Reduction in missed 28 day cancer decisions	Actual	76%	Consistent with prior months

Appendix C: HWE Adult Community Services

Elective & Specialist	E&NH	S&WH	West Essex
Cardiac Rehab	HCT/ENHT	CLCH	EPUT
Diabetes	HCT	HCT	EPUT
Continence services	HCT	CLCH	EPUT
Nutrition and Dietetic Service	HCT	HCT	EPUT
Speech and language therapy	HCT	CLCH	EPUT
Podiatry	HCT	CLCH	EPUT
Specialist palliative care	HCT	CLCH	EPUT
Heart failure service	-	CLCH	EPUT
Lymphoedema	HCT	CLCH	HCT
Tissue Viability	HCT	CLCH	EPUT
Leg Ulcer	HCT	CLCH (Herts one)	EPUT
Respiratory	HCT/ENHT	CLCH/WHHT	EPUT
MSK	HCT	Connect	EPUT
Chronic pain management	HCT	Connect	EPUT
Community Neuro/rehab	HCT	CLCH	PD/MS only
Pulmonary Rehab	HCT	CLCH	EPUT
Specialist Dentistry	HCT	HCT	-
Community Dermatology	HCT	-	GP Fed
Community ENT	-	Communitas	-
Community Gynaecology	-	The Gynaecology partnership	-
Long Covid	HCT	CLCH	EPUT
Diabetes eye screening	ENHT	HCT	Health intelligence Ltd
Sexual Health Services	CLCH	CLCH	Provide

Urgent & Emergency Services	E&NH	S&WH	West Essex
2 hour urgent response	HCT	CLCH	EPUT
Hospital at home/rapid response	HCT	CLCH	EPUT
Discharge to assess (at home)	HCT	CLCH	EPUT
Virtual ward/hospital	HCT	CLCH/WHHT	EPUT
Inpatient rehab beds	HCT	CLCH	EPUT
Inpatient stroke Neuro rehab beds	HCT	CLCH	EPUT
Respiratory services	HCT	CLCH	EPUT
Stroke (Early supported discharge)	HCT	CLCH	EPUT
Neuro ESD (NETT)	-	CLCH	-

Core community Services	E&NH	S&WH	West Essex
District Nursing	HCT	CLCH	EPUT
Community therapies (OT/PT)	HCT	CLCH	EPUT
Frailty clinics	HCT	CLCH	PAH
Enhanced health in care homes	HCT	CLCH	EPUT

Appendix C: HWE Children's Community Services

Children's Services within Hertfordshire and West Essex ICS is complex with a range of existing governance forums and a broad range of services provided primarily by NHS Trusts, but with a number of independent and 3rd sector organisations

Service	E&NH	S&WH	West Essex
ADHD	ENHT	HPFT	HCRG
Advocacy	KIDS	KIDS	Rethink / Open Door
Allergy	ENHT	WHHT	HCRG / PAH
ASD	ENHT	HCT	HCRG
Asthma Nurse specialist	n/a	HCT	To be established
Audiology	ENHT	HCT	PAH
Wellbeing Practitioners	HCT	HCT	HCRG
CHIS	HCT	HCT	Provide
Com. Nursing	ENHT	HCT	HCRG
Comm Paeds	ENHT	HCT	HCRG
Continence	n/a	HCT	HCRG
Continuing Care	ENHT	HCT	HCRG & Various Independent
CSAIS	EPUT (s/c HCT)	EPUT (s/c HCT)	EPUT
CYP Counselling	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT, Youthtalk, Signpost, Rephael House & Safespace.	YCT
CYP Therapies	HCT	HCT	HCRG (SLT inclusive of dysphagia, PT inclusive of MSK)
Designated Medical Officer for SEND	ENHT	HCT	HCRG
Diabetes Nurse Specialist	ENHT	WHHT	PAH
Dietetics	HCT	HCT	HCRG / PAH
Eating Disorders	HPFT	HPFT	NELFT / BEAT
Epilepsy Nurse Specialist	ENHT	WHHT	PAH
Equipment	HCT	HCT	EPUT
Eye Care	ENHT	HCT/WHHT	PAH

Service	E&NH	S&WH	West Essex
Family Hubs/Children's Centres	Family Centre Services/Family Support Services/ HCT	Family Centre Services/Family Support Services/ HCT	HCRG
Health Visiting	HCT	HCT	HCRG
Hospice Care	Keech	Keech/Noah's Arc/ Rennie Grove	Haven House, EACH
Infant Mental Health	HCT	HCT	EPUT
LAC	HCT	HCT	HCRG
Lymphoedema	HCT	n/a	HCT
Mental Health Support Teams	HPFT/HCT	HPFT/HCT	West Essex Mind (mainstream) / HPFT (special schools)
Neuro-Rehab	Specialist commissioned	Specialist commissioned	Tadworth Children's Trust
Palliative Care Respite Service (EPIC)	Noah's Arc	Noah's Arc	Little Haven's
Palms	HCT	HCT	n/a
Parenting Support	HCC	HCC	Triple P (YCT from April)
Perinatal Mental Health	HPFT	HPFT	EPUT
School Nursing	HCT	HCT	HCRG
Sickle cell	HCT	HCT	PAH
Special care dentistry	HCT	HCT	PAH
Specialist CAMHS	ENHT	HPFT	NELFT
Specialist Healthcare Tasks	n/a	n/a	Provide
Specialist school nursing	ENHT	HCT	HCRG
Step 2 Service	JHCT	HCT	n/a
Therapeutic Health Based Coaching	n/a	n/a	NOW
Tier 4 CAMHS	HPFT	HPFT	EPUT
Transition coordinators	HCT	HCT	HCRG
Weight Management & other wellbeing services	Beezee Bodies	Henri/ Beezee Bodies	Provide

N.B. Virgin Care has now been transferred to HCRG Care Group

Glossary of Acronyms

>104 days	Cancer backlog greater than 104 days
>104 weeks	Elective Care backlog greater than 104 weeks
>62 days	Cancer backlog greater than 62 days
A&E	Accident & Emergency
AAU	Ambulatory Assessment Unit
AHC	Annual Health Check
BAME	Black Asian & Minority Ethnic
BAU	Business As Usual
CAMHS	Children & Adolescent Mental Health Service
CCATT	Children Crisis Assessment & Treatment Team
CCG	Clinical Commissioning Group
CDC	Cancer Diagnostic Centre
CEO	Chief Executive Officer
CHC	Continuing Healthcare
CISS	Community Intensive Support Service
CLCH	Central London Community Healthcare NHS Trust
CMO	Chief Medical Officer
CO	Carbon Monoxide
CQC	Care Quality Commission
CT	Computerised Tomography (scan)
CYP	Children Young People
D2A	Discharge to Assess
DMAS	Digital Mutual Aid System
DQ	Data Quality
DST	Decision Support Tool
DSX	DSX Systems (Digital Health Solutions)
DWP	Department for Work & Pensions
EAU	Emergency Assessment Unit
ECHO	Echocardiogram

ED	Emergency Department
EEAST	East of England Ambulance Service NHS Trust
EIP	Early Intervention in Psychosis
EMDASS	Early Memory Diagnosis and Support Service
EMIS	Supplier of GP Practice systems and software
ENHCCG	East & North Herts Clinical Commissioning Group
ENHT	East & North Herts NHS Trust
EPR	Electronic Patient Record
EPUT	Essex Partnership University NHS Foundation Trust
F2F	Face-to-Face
FDS	Cancer 28 day Faster Diagnosis Standard
FHAU	Forest House Adolescent Unit
FNC	Funded Nursing Care
GP	General Practice
HALO	Hospital Ambulance Liaison Officer
HCA	HealthCare Assistant
HCT	Hertfordshire Community Trust
HEG	Hospital Efficiency Group
HPFT	Hertfordshire Partnership NHS Foundation Trust
HUC	Hertfordshire Urgent Care
HVCCG	Herts Valley Clinical Commissioning Group
IAG	Inspection Action Group
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IPC	Infection prevention and control
IS	Independent Sector
IUC	Integrated Urgent Care

JSPQ	Joint Service, Performance and Quality Review Meeting
LA	Local Authority
LAC	Look After Children (team)
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LFT	Lateral Flow Test
LMNS	Local Maternity Neonatal System
LMS	Local Maternity System
LoS	Length of Stay
MDT	Multi Disciplinary Teams
MH	Mental Health
MHSOP	Mental Health Service for older People
MOU	Memorandum Of Understanding
MRI	Magnetic Resonance Imaging
MSE	Mid & South Essex NHS Foundation Trust
NHSE / I	NHS England & Improvement
NICE	The National Institute for Health & Care Excellence
NLMCTR	No Longer Meets Criteria To Reside
NO	Nitrous Oxide
NOK	Next Of Kin
OHCP	One HealthCare Partnership
OOAP	Out of Area Placements
OT	Occupational Therapy
PAH / PAHT	The Princess Alexandra Hospital NHS Trust
PCN	Primary Care Network
PCR	Polymerase Chain Reaction (test)

PEoLC	Palliative & End of Life Care
PIFU	Patient Initiated Follow-Up
PMO	Project Management Office
PRISM	Primary Integrated Service for Mental Health
PTL	Patient Tracking List
RCA	Root Cause Analysis
REAP	Resource Escalation Action Plan
RESUS	Resuscitation
RTT	Referral to Treatment (18-week elective target)
SACH	St Albans City Hospital
SAFER	Tool to reduce patient flow delays on inpatient wards
SDEC	Same Day Emergency Care
SLT	Speech & Language Therapist
SMART	Surge Management and Resilience Toolset
SRG/LDB	System Resilience Group / Local Delivery Board
SSNAP	Sentinel Stroke National Audit Programme
T&O	Trauma and Orthopaedic
TTA	Take Home Medication (To Take Away)
UEC	Urgent Emergency Care
US	Ultrasound Scan
UTC	Urgent Treatment Centre
WAF	Winter Access Fund
WECCG	West Essex Clinical Commissioning Group
WGH	Watford General Hospital
WHHT	West Herts Hospital Trust
WW	Week Waits

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	16
Report title	Audit and Risk Committee 11 July 2023 highlights report			**Meeting Date**	6 September 2023
Chair	Karen McConnell – Acting Audit and Risk Committee Chair and Non-Executive Director				
Author	Karla West – Assistant Trust Secretary (interim)				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Internal Audit Progress Report
- Counter Fraud Progress Report
- Audit Report Log
- Annual Accounts 2022-23
- Annual Report 2022-23
- External Audit Completion Report
- Risk Report and Corporate Risk Register
- Anti-Fraud and Bribery policy
- Significant Losses / Special Payments
- Cyber Security Report
- Data Quality and Digital Coding Report

Alert:

- The BDO's opinion on the Trusts Annual accounts for the year ended 31 March 2023 remains outstanding and will be issued after the due date. NHSE have been kept informed.
- The Auditors anticipate issuing an unmodified opinion on the accounts. They will report a significant weakness in respect of the Trust's value for money arrangements for 2022/23 in respect of financial sustainability. This primarily relates to CIP arrangements during the year. Steps taken by the Trust in 2023/24 to address the issue were noted.
- The Auditors are required to issue the Annual Auditors Report at the same time as the opinion on the financial statements but are unable to meet that timescale and have set out their reasons in a letter within their report. Completion of the work is anticipated by 10 October 2023.

Advise:

- The Committee approved the Trust's 2022/23 Annual Report and Annual Governance Statement under delegated authority from the Board.
- Slow progress is being made with clearing outstanding recommendations with 21 overdue recommendations awaiting implementation.
- Significant progress has been made with risk management and the corporate risk register. The need to consider responses to and mitigation of corporate risks was noted.
- Pharmacy stock losses amounted to over £127,000. The amount was reduced from

the year before but with a peak in the final quarter. Losses arise from expired stock and fridge and freezer malfunctions. Total losses arising from patient claims in 2022/23 were higher in both value and volume than for 2021/22	
Assurance:	
• Ward Discharge Practices and Complaints audits have recently been completed by SICA with reasonable assurance opinions being provided for both. • The Trusts Annual Counter Fraud Functional Standard Return was submitted by the deadline of 31 May 2023. The provisional overall rating was green. •	
Important items to come back to committee (items committee keeping an eye on):	
• The Auditors Annual Report including the commentary on arrangements to secure value for money is expected to be issued by 10 October 2023. • Further work to be undertaken regarding data quality. Updates to be provided to the Committee in due course.	
Items referred to the Board or a committee for a decision/action:	
N/A	
Recommendation	The Board is asked to **NOTE** the Audit and Risk Committee report

To be trusted to provide consistently outstanding care and exemplary service

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	17
Report title	Finance, Performance and Planning Committee 25 July Highlight Report	**Meeting Date**	6 September 2023
Chair	Karen McConnell - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- Urgent Emergency Care Spotlight
- Finance Report – Month 3
- Deficit Management Framework
- HWE Finance MOU and 23/24 DoFs Workplan
- Capital Project Manual
- CIP Project Update
- Divisional CIP Plan Unplanned Care Division
- Productivity and ERF Report
- Elective Surge Hub – Working Arrangements
- Performance Report
- Infrastructure Development Procurement Update
- Outpatient Strategy Spotlight

Alert:

- The elective surge hub is now facing a capital gap of £6.1 million. A subset of the Elective Care Hub Programme board convened on 13 July '23 to evaluate the possibilities and decide on next steps. A decision was taken to approach NHSE to request further national funds. Delay and/or cancellation of the scheme would compromise the systems ability to respond to waiting list and waiting time targets. Risks and opportunities for ENHT in the elective care hub revenue model were discussed by the Committee.

Advise:

- Unplanned care has made progress in closing the CIP gap for the year. The revised plan delivers £6.3m against its target of £7.6m and opportunities are being scoped to close the gap. For the year to date Unplanned Care has met its CIP target.
- FPPC were presented with an overview of planned changes to the 2023/34 Urgent and Emergency care pathway. The 6 key projects to achieve the 4 hour performance target by 31 March 2024 were discussed and risks noted. The QE11 consistently delivers high performance against the 4 hour standard (circa 99%). Lister (paediatrics and adults) needs to improve from 44.2% in April to 62.5%. The improved flow arising from the projects should improve ambulance handover times and this key KPI will be closely monitored.

- The 4 hour direct to stoke unit standard is an ongoing challenge as it is nationally. Plans to improve flow should also help address stroke performance together with other actions already in train.
- At month 3 year to date the Trust delivered a deficit of £6m which was £0.4m adverse to plan. The reported position includes the impact of the 2nd industrial action this financial year. The cost is £0.3m to the end of June.
- The CIP performance to date is on plan. The phasing of the plan was noted.
- The Committee were concerned about the overspend of £0.54m on the Clinical Support workers where increased spend on additional substantive staff has not been matched by a reduction in bank spend.
- A draft proposal for infrastructure development has been prepared and will be tested with auditors during the second quarter of 2023/24.

Assurance:

- The Capital Project Manual was approved in principle subject to amendments to be discussed.
- The Committee reviewed and supported the implementation of the deficit control framework.
- The Committee noted and supported the change in approach summarised in core documents agreed by the Directors of Finance for the HWE system to respond to the challenges and limitations exposed in this years planning process. The need for transparency across the system was emphasised by the Committee.
- The productivity and ERF report was discussed and will support the Trusts ability to plan and monitor key dimensions of productivity and efficiency
- The programme update on the Outpatient Strategy provided the requested estimate of potential improvements in outpatient efficiency and productivity stemming from the various improvement plans.

Important Items to come back to committee:	- Update on Elective Surge Hub capital gap. - Plans to resolve deficit management control gaps.
Items referred to the Board or a Committee for decision or action:	None.

Recommendation	The Board is asked to **NOTE** the Finance, Performance and Planning report.

Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board			**Agenda Item**	18
Report title	Quality and Safety Committee 26 July 2023 highlight report			**Meeting Date**	6 September 2023
Chair	Peter Carter – Committee Chair and Non-Executive Director				
Author	Karla West – Assistant Trust Secretary (Interim)				
Quorate	**Yes**	☒	**No**		☐

Agenda:

- Fundamentals
- Safe, Care, Effective Report
- Maternity Assurance Report
- Risk Management and Quarterly Compliance Report
- Quarterly Complaints and Patient Experience Report
- Estates and Facilities Compliance Report
- Clinical Ethics Group Annual Report
- Escalation Reports

Alert:

- The Police have indicated their intention to pull out of maintaining onsite security from December 2023.
- Ophthalmology Department are reporting concerns as patients are waiting too long to be seen.

Advise:

N/A

Assurance:

- Estates and Facilities are updating policies in order to maintain assurance levels.

Important items to come back to committee (items committee keeping an eye on):

N/A

Items referred to the Board or a committee for a decision/action:

N/A

Recommendation	The Board is asked to **NOTE** the Quality and Safety Committee report

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Report Coversheet

East and North Hertfordshire NHS Trust

Meeting	Public Trust Board	**Agenda Item**	19
Report title	People Committee 18 July Highlight Report	**Meeting Date**	6 September 2023
Chair	Val Moore - Committee Chair and Non-Executive Director		
Author	Chloe Milton – Committee Secretary		
Quorate			
	Yes ☒	**No** ☐	

Agenda:

- People Report
- Divisional update
- Voice of our people – carers networks
- Health and wellbeing
- Workforce Race Equality Scheme (WRES) – Data/action plan submission
- Workforce Disability Equality Scheme (WDES) – Data submission
- Freedom to speak up
- Clinical Excellence awards
- Statutory mandatory training and Technology enhanced learning (TEL)
- E-roster/workplace deployment
- Strategic food review
- Board assurance framework

Alert:

- Statutory mandatory training: To tackle compliance rates, a direct approach was being tried by proactively emailing personnel to remind them of outstanding training. However, this had not significantly improved compliance rates.
- Strategic food review: whilst changes had been made to meet the new national food and drinks standards such as healthy options, there remained the issue of no hot food during the night.
- E-rostering: the Committee queried the impact of e-rostering and requested a paper on e-rostering to better understand potential benefits.
- WRES: Whilst 8a and above diversity was improving, diversity on the Board was highlighted.
- WDES: NHSE are challenging the progress on disability recording and addressing under-recording of disability. At the Trust, since 2019, 8a and above disability numbers have increased from 19% to 26% in 2023.
- Freedom to Speak Up: 62% of concerns are about workplace safety and welfare, including work-related stress and relationship breakdowns between managers and employees. Behaviours were at 23%, including workers not feeling respected, indicating management training would be beneficial to better support staff (see Freedom to Speak Up annual report paper).

Advise:	
- Grow together reviews are being conducted and the completion target remains the end of August. - The Committee Chair requested the values set out in the divisional report be displayed prominently in relevant staff areas. - Board Assurance Framework: The Committee concluded that whilst there had been a number of actions to tackle the culture risk, the risk score needed to remain the same until there was strong evidence of progress such as Staff Survey scores. - Going forward weekly doctors' newsletter will include a section relating to career networks to promote more staff to speak up.	
Assurance:	
- The draft Equality, Diversity and Inclusion strategy has been distributed for staff network input, with helpful discussions and feedback from the networks - The work that the black, Asian and minority ethnics (BAME) network have conducted is beginning to have traction, which is seeing numbers wishing to join this staff network increase. - Divisional huddles and workshops are being used as means for staff to feel heard and seen in relation to any concerns they may have.	
Important Items to come back to committee:	- Achieving compliance rates for statutory mandatory training and Grow Together reviews - A paper on e-rostering to better understand potential issues and the way forward.
Items referred to the Board or a Committee for decision or action:	None.

Recommendation	The Board is asked to **NOTE** the People Committee report.

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Board Annual Cycle 2023-24

Notes regarding the annual cycle:

The Board Annual Cycle will continue to be reviewed in-year in line with best practice and any changes to national scheduling.

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Standing Items												
Chief Executive's Report		X		X		X		X		X		X
Integrated Performance Report		X		X		X		X		X		X
Board Assurance Framework				X				X				X
Corporate Risk Register		X				X				X		
Patient/Staff Story (Part 1 where possible)		X		X		X		X		X		X
Employee relations (Part 2)		X		X		X		X		X		X
Board Committee Summary Reports												
Audit Committee Report		X		X		X		X				X
Charity Trustee Committee Report		X		X				X		X		
Finance, Performance and Planning Committee Report		X		X		X		X		X		X
Quality and Safety Committee Report		X		X		X		X		X		X
People Committee		X		X		X		X		X		X
Strategy												
Planning guidance										X		
Trust Strategy refresh and annual objectives												X
Strategy delivery report				X [previous year]						X		
Strategic transformation & digital update				X				X				X
Integrated Business Plan								X				

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Annual budget/financial plan												X
Digital Strategy Update				X				X				
System Working & Provider Collaboration (ICS and HCP) Updates		X		X		X		X		X		X
Mount Vernon Cancer Centre Transfer Update (Part 2)		X		X		X		X		X		X
Estates and Green Plan								X				
Workforce Race Equality Standard										X		
Workforce Disability Equality Standard										X		
Equality, Diversity and Inclusion												
Clinical and Quality Strategies												X
People Strategy										X		
Other Items												
Audit Committee												
Annual Report and Accounts, Annual Governance Statement and External Auditor's Report – Approval Process		X										
Value for Money Report						X						
Audit Committee TOR and Annual Report				X								
Review of Trust Standing Orders and Standing Financial Instructions		X										
Charity Trustee Committee												
Charity Annual Accounts and Report								X				
Charity Trust TOR and Annual Committee Review												X

Board Annual Cycle 2023-24

Items	5 April 2023	3 May 2023	7 June 2023	5 Jul 2023	Aug 2023	6 Sept 2023	4 Oct 2023	1 Nov 2023	6 Dec 2023	Jan 2024	Feb 2024	Mar 2024
Finance, Performance and Planning Committee												
Finance Update (IPR)		X		X		X		X		X		X
FPPC TOR and Annual Report				X								
Quality and Safety Committee												
Complaints, PALS and Patient Experience Annual Report						X						
Safeguarding and L.D. Annual Report (Adult and Children)								X				
Staff Survey Results		X										X
Learning from Deaths		X				X		X		X		
Nursing Establishment Review										X		
Patient Safety and Incident Report (Part 2)		X						X				
University Status Annual Report				X								
QSC TOR and Annual Review				X								
People Committee & Culture												
Workforce Plan								X				
Trust Values refresh				X								
Freedom to Speak Up Annual Report								X				
Staff Survey Results		X										
Equality and Diversity Annual Report and WRES						X						
Gender Pay Gap Report		X										
People Committee TOR and Annual Report								X				
Shareholder / Formal Contracts												
ENH Pharma (Part 2) shareholder report to Board				X						X		